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Annual report 2007: the state of the drugs problem in Europe

was published by the European Monitoring Centre for Drugs and Drug Addiction on 22 November 2007.

Topics of interest in the report include the rise in cocaine use, drug use among under-15s, and drugs and driving.

This report is covered on p. 18 of this issue.

Health-related consequences of problem alcohol use

On 1 November the Alcohol and Drug Research Unit of the Health Research Board published Overview 6, *Health-related consequences of problem alcohol use*.[1] The purpose of this Overview was to compile and analyse the available data on problem alcohol use in Ireland and its health-related consequences. It is hoped that this will help determine what approaches are likely to be effective in reducing alcohol-related harm, and identify gaps in current knowledge so as to inform future research needs in this area.

Dr Deirdre Mongan, author of *Health-related consequences of problem alcohol use*, at a media briefing on the report in the HRB. (Photo: JJ Berkeley)

Ireland has one of the highest levels of alcohol consumption in the European Union. In 2006, the average rate of consumption of pure alcohol per adult (aged 15 years or over) was 13.36 litres. This compares to a rate of 11.38 litres in 1995 and represents an increase of 17%. Alcohol consumption increased steadily between 1995 and 2001, when it peaked at 14.3 litres per person. The first notable decrease occurred in 2003, when consumption decreased by 6%, which is widely attributed to the increase in excise duty on spirits in the 2002 budget. Since 2003, the level of alcohol consumption has remained static.

As well as being among the highest alcohol consumers in Europe, people in Ireland engage in drinking patterns that are excessive and problematic, with heavy and binge drinking now the norm for a substantial number of people. A number of population studies have confirmed this, both in adults and in young people.

In order to study alcohol-related harm in Ireland, data from the Hospital In-Patient Enquiry (HIPE) scheme, maintained by the Economic and Social Research Institute (ESRI), and from the General Mortality Register (GMR), maintained by the Central Statistics Office (CSO), were analysed for the years 1995–2004. Alcohol treatment in Ireland was analysed using data from the National Drug Treatment Reporting System (NDTRS) and the National Psychiatric In-Patient Reporting System (NPIRS), both of which are maintained by the Health Research Board.

According to the HIPE data, there were 139,962 alcohol-related discharges n the 10 years between 1995 and 2004. Annual figures rose from 9,254 in 1995 to 17,378 in 2004. People with alcohol-related illness used 117,373 bed days in hospitals in 2004, accounting for 2.9% of all bed days that year, compared to 55,805 bed days in 1995.

Men accounted for 75% of the cases discharged from hospital and women accounted for 25%. Discharges peaked in the 50–59 age range. Over 26,000 discharges were aged 30 or under. Four out of five of this group had acute problems, but over 5,000 had chronic conditions or alcohol-related liver disease. This is extremely worrying, given that it takes a number of years of hazardous drinking to develop chronic conditions.

The results also highlight some serious implications for women's health. The age profile of the women discharged from hospital was much lower than that of the men. While women accounted

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Health-related consequences of alcohol *(continued)*

for just 25% of all discharges in the 10-year period, in 2004 they accounted for 47% of discharges under the age of 18. This is not surprising as a number of studies have indicated that alcohol consumption has increased substantially among young girls since 1995. If alcohol consumption among young Irish women continues to follow current trends, it is likely that the number of middle-aged women experiencing alcohol-related morbidity will increase in the future.

A total of 1,775 people died from alcohol-related causes between 1995 and 2004, with men twice as likely to die from an alcohol-related cause. A total of 68% of these deaths were in people aged 60 or under. To put this in perspective, only 21% of deaths in the general population in this period were under 65 years of age, highlighting the increased risk of premature death associated with alcohol use.

During 2005, 5,527 people received treatment for problem alcohol use, according to the NDTRS, and 2,995 people were admitted to psychiatric units for alcohol-related illness, according to the NPIRS. Data from the NDTRS reveal that 2,827 people entered treatment for the first time in 2005. However, as coverage for alcohol treatment agencies is still incomplete, it can be reliably assumed that the number presenting for treatment is actually much higher. Treatment figures also show that one in five people receiving treatment for alcohol are using at least one other drug. This is increasingly common among young people, with 8% of people treated for use of more than one drug aged 17 or under, compared to 1.6% of the same group treated for alcohol only.

This Overview emphasises the need to reduce alcohol consumption in Ireland. There is a clear link between levels of consumption and alcohol-related harm. For example, the two years of highest consumption – 2001 and 2002 – coincide with the highest numbers of deaths and discharges; and in 2003, the first decrease (of 6%) in consumption also coincides with the first decrease (of 2%) in alcohol-related discharges. International evidence supports alcohol taxation, regulating the physical availability of alcohol and drink-driving countermeasures as effective strategies for reducing alcohol consumption and related harm.

This Overview also highlights the need for accurate and complete data on those receiving treatment as well as greater integration of alcohol and drug services, given the high level of polydrug use. There is also a need to identify those with hazardous drinking patterns in a variety of settings before they begin to experience alcohol-related harm.

(Deirdre Mongan)

1. Mongan D, Reynolds S, Fanagan S and Long J (2007) *Health-related consequences of problem alcohol use. Overview 6.* Dublin: Health Research Board.

Alcohol consumption in Ireland

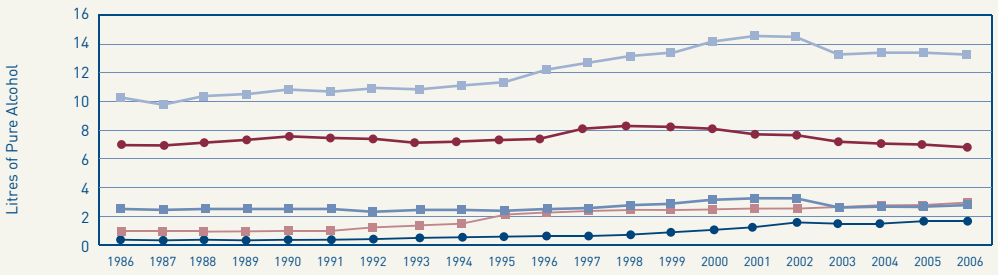
The recently published report, *Alcohol consumption in Ireland 1986–2006,*[1] written by Dr Anne Hope for the Health Service Executive – Alcohol Implementation Group, explains how alcohol consumption in Ireland is measured and describes trends in consumption since 1986.

Alcohol consumption is measured by dividing the total alcohol sales figures provided by the Revenue Commissioners by the population figures provided by the Central Statistics Office (CSO). The Revenue Commissioners compile annual alcohol sales figures based on the volume of each alcoholic beverage type (beer, spirits, wine and cider) released from bonded warehousing on payment of excise duty. The figures for beer and spirits are given in litres of pure alcohol. Figures for wine and cider are given by total volume, and the pure alcohol content is calculated based on an ABV (alcohol by volume) rate of 12.5% in the case of wine and 4.5% in the case of cider.

Consumption of alcohol per capita and per adult in the total population is calculated using the total sales figure for pure alcohol as outlined above and dividing it by the population figures provided by the CSO. Given that 21% of the Irish population is aged under 15 years, it is generally considered that the rate of consumption of pure alcohol per adult (aged 15 years or over) is a more accurate reflection of consumption at a population level than the per capita rate. Since 1986 there has been a gradual increase in the proportion of adults in the population, which is an important factor when interpreting alcohol consumption figures and comparing consumption trends over time.

Alcohol consumption per adult increased from 9.8 litres of pure alcohol in 1987 to a peak of 14.3 litres in 2001, an increase of 46%. The period of most rapid increase was from the mid-1990s to 2001 (Figure 1). Consumption decreased by 6% between 2002 and 2003. From 2004 onwards, consumption levels have remained quite static. Beer is the most widely consumed alcoholic beverage in Ireland and accounted for 6.82 litres of pure alcohol per adult in 2006, which is similar to the level consumed in 1986 (6.93 litres). Beer

Alcohol consumption in Ireland *(continued)*



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Beer	6.93	6.74	6.91	7.29	7.61	7.49	7.71	7.39	7.46	7.58	7.89	8.04	8.33	8.25	8.05	7.93	7.71	7.39	7.19	7.04	6.82
Spirits	2.36	2.20	2.34	2.30	2.35	2.34	2.18	2.22	2.20	2.12	2.30	2.37	2.47	2.75	3.04	3.08	3.17	2.49	2.51	2.51	2.56
Wine	0.62	0.62	0.68	0.72	0.76	0.78	0.83	0.94	0.97	1.06	1.26	1.34	1.55	1.72	1.87	2.06	2.27	2.41	2.71	2.75	2.87
Cider	0.20	0.21	0.20	0.21	0.25	0.30	0.37	0.42	0.48	0.63	0.69	0.77	0.88	1.00	1.13	1.23	1.07	1.06	1.06	1.09	1.09
Total	10.10	9.77	10.14	10.51	10.96	10.92	11.09	10.98	11.11	11.38	12.14	12.53	13.23	13.72	14.08	14.30	14.22	13.35	13.48	13.40	13.34

Figure 1 Alcohol consumption per adult by beverage type, 1986–2006
Source: Revenue Commissioners and CSO annual reports

consumption peaked in 1998, when 8.33 litres of pure alcohol per adult was consumed as beer. Since then, beer consumption has been decreasing. Other noticeable trends in the type of drink consumed include the rise in popularity of wine, with an increase of 363% between 1986 and 2006, from 0.62 to 2.87 litres per adult. The consumption of spirits increased steadily between 1995 and 2002 (up 42%) but decreased by 21% in 2003 following an increase in excise duty. A similar trend is noticeable for cider, with consumption increasing by 515% between 1986 and 2001, from 0.20 to 1.23 litres per adult. An increase in excise duty in December 2001 resulted in a 13% reduction in cider consumption in 2002. In 2004, for the first time, consumption of wine exceeded that of spirits.

Beer still has the largest market share of any alcoholic beverage, although its consumption is decreasing and its market share fell from 69% in 1986 to 51% in 2006 (Table 1). Wine has shown the greatest increase in popularity in the past 20 years, from 6% to 21%, and now has a higher market share than spirits. The market share of cider has also increased, from 2% in 1986 to 8% in 2006.

While alcohol consumption decreased from a peak of 14.3 litres of pure alcohol per adult in 2001 to 13.3 in 2006, Ireland remains among the top alcohol-consuming countries in Europe, after Luxembourg and Hungary. In 2003, the average consumption per adult in the enlarged European Union was 10.2 litres, compared to 13.4 litres in Ireland.

This report demonstrates that alcohol consumption has increased substantially in the past 20 years and Ireland now consumes more alcohol per adult than most of its European counterparts. There has also been considerable change in the choice of beverage consumed, with beer declining in popularity and wine and cider showing considerable increases in market share.

(Deirdre Mongan)

1. Hope A (2007) *Alcohol consumption in Ireland 1986–2006.* Report for the Health Service Executive – Alcohol Implementation Group. Dublin: Health Service Executive.

Table 1 Consumption of alcohol by market share of each beverage, 1986–2006

Litres of pure alcohol per adult	1986	1991	1996	2001	2006
	10.1	10.9	12.1	14.3	13.3
Market share	**%**	**%**	**%**	**%**	**%**
Beer	69	69	65	55	51
Spirits	23	21	19	21	19
Wine	6	7	10	14	21
Cider	2	3	6	9	8

'No safe level of alcohol consumption during pregnancy'

On 7 September 2007, Mr Pat the Cope Gallagher TD, Minister for Health Promotion and Food Safety, highlighted the risk of alcohol consumption in pregnancy. Minister Gallagher stated: 'I wish to endorse the advice being given today by the Department of Health and Children's Chief Medical Officer. It is essential that women are provided with all the relevant information for a safe and successful pregnancy. Therefore, women need to be aware of the risk associated with alcohol consumption during pregnancy. As the evidence does not specify a safe level of alcohol consumption, the best advice to women is not to consume alcohol if pregnant or trying to conceive.'[1]

The minister's statement follows the publication of a report earlier this year entitled The Coombe Women's Hospital study of alcohol, smoking and illicit drug use, 1988–2005[2], which found that most pregnant women drink alcohol, with one in 10 drinking more than six units per week, a pattern more pronounced in younger women. Following this publication, Mary Harney TD, Minister for Health and Children, asked the Chief Medical Officer (CMO) to consider the data presented in the study. The CMO also reviewed the available international evidence, including that from the Surgeon General in the US and the Department of Health in the UK.

The CMO has concluded that 'there is no safe level of alcohol consumption during pregnancy', and has given unambiguous advice on the matter, stating: 'Given the harmful drinking patterns in Ireland and the propensity to "binge drink", there is a substantial risk of neurological damage to the foetus resulting in Foetal Alcohol Spectrum Disorders (FASD). Alcohol offers no benefits to pregnancy outcomes. Therefore, it is in the child's best interest for a pregnant woman not to drink alcohol during pregnancy.'

The Health Service Executive (HSE) will commence work on updating information material for use by the general public and medical professionals to include the CMO's advice that women should avoid alcohol before and during pregnancy and while breastfeeding. The HSE will also meet with relevant stakeholders with regard to developing and implementing education initiatives on this issue for health professionals. The Department of Health and Children is consulting with relevant stakeholders on the proposal to introduce a requirement that alcohol containers and promotional material carry a health warning about drinking alcohol during pregnancy.

(Deirdre Mongan)

1. Department of Health and Children (2007) Minister Gallagher renews advice to women not to drink alcohol in pregnancy. Press release, 7 September. Retrieved 12/09/2007 from http://www.dohc.ie/press/releases/2007/20070907.html.
2. Barry S, Kearney A, Lawlor E, McNamee E and Barry J (2006) *The Coombe Women's Hospital study of alcohol, smoking and illicit drug use, 1988–2005.* Dublin: Coombe Women's Hospital.

Voluntary alcohol advertising codes still on probation

In July 2007 the Alcohol Marketing Communications Monitoring Body submitted to the Minister for Health its first annual report on the implementation of and adherence to the voluntary codes of alcohol advertising.[1] Drawn up by the Drinks Industry Group of Ireland, the Association of Advertisers in Ireland and representatives of the media, the codes are intended to limit the exposure of under-18s to alcoholic drink advertising.[2]

During 2006 the Monitoring Body found there was overall compliance with the voluntary codes. Where identified breaches had occurred, the Body was generally satisfied that immediate remedial action had been taken and measures introduced to prevent a recurrence. However, the Body called on the media partners to put procedures in place to prevent breaches occurring in the first place.

The Monitoring Body made the following recommendations:

- Television: Broadcasters should be careful when scheduling alcohol advertising during school mid-term breaks and holidays, and during certain sporting events, such as the 2006 World Cup, as it is possible that higher than normal numbers of young people might be watching.
- Cinema: Consideration should be given to the practice of placing an advertisement for alcohol outside of the main advertising reel, after the film certification information and before the start of the film.
- Radio: The Independent Broadcasters of Ireland (IBI) should be encouraged to develop the Code of Conduct for Presenters, which should be applicable to all member stations.
- General: The media partners might wish to examine the issue of electronic media, which is not covered under the current Codes.

The Minister of State at the Department of Health, Pat the Cope Gallagher TD, has outlined the government's response to the Monitoring Body's report:

> Following consideration of the Report my Department has decided to commence discussions with the relevant stakeholders with a view to strengthening and expanding the current voluntary codes on alcohol marketing and communications in order to provide significantly greater protection for children and young

Alcohol advertising codes *(continued)*

people. I will give further consideration to the possibility of using legislation in this area depending on the outcome of these discussions.[3]

(Brigid Pike)

1. Alcohol Marketing Communications Monitoring Body (2007) *Limiting the exposure of young people to alcohol advertising.* First annual report 2006. Retrieved 29 November 2007 from www.dohc.ie
2. For an account of the establishment and purpose of the Monitoring Body, see Pike B (2006) Self-regulation of alcohol advertising is on probation. *Drugnet Ireland* 17: 6.
3. Gallagher P the Cope (2007, 21 November) *Parliamentary Debates Dáil Éireann Official Report: Unrevised.* Vol. 642, col. 234, PDF version. Available at www.gov.ie/oireachtas/frame.htm

Social reintegration as a response to drug use in Ireland: an overview

A new research report examining the association between aspects of social exclusion, problematic drug use and social reintegration as a response to this type of drug use in Ireland was launched on 6 November by the Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB).[1]

Social exclusion, in the form of homelessness and insecure accommodation, inadequate education and poor employment skills, is closely associated with problematic drug use. As a response, social reintegration has emerged as a key aspect of drug treatment and rehabilitation in order to provide responses to accommodation, education, and vocational training and employment support requirements of problem drug users.

Social reintegration of problematic users is not a new concept; indeed, it has been around since the early 1960s.[2] The first attempt to include social reintegration measures in Irish drug policy occurred in the 1971 *Report of the working party on drug abuse*.[3] Subsequent drug policy development in 1991, 1996 and 2001 emphasised the importance of linking vocational training and employment skills with drug treatment.[4-6] Since 2000, the Council of the European Union has urged member states to improve availability of, and access to, social reintegration services for drug users, and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and National Focal Points (NFPs) have been asked to monitor and report on the accessibility and availability of such measures in members states throughout the EU.[7,8]

This Overview brings together information on the association between unemployment, homelessness and problem drug use in Ireland and examines how drug policy and practice have responded to this situation. This information comes from in-depth interviews with service providers, an exploration of research and evaluation and policy documents and an analysis of data from the National Drug Treatment Reporting System (NDTRS). The main findings from an extensive literature search indicate that failure to address unemployment and homelessness among drug users can undermine treatment gains and lead to social exclusion.

Early chapters include an executive summary and details of the background and structure of the report and the data sources used. Chapter three presents the background to

Mr Martin Keane, author of *Social reintegration as a response to drug use in Ireland.* (Photo: JJ Berkeley)

the development of social reintegration as a concept and examines the extent to which drug policy and practice in Ireland have understood the concept. Despite policy proposals to improve educational levels and employability among drug users in Ireland since the early 1970s, in practice, social reintegration measures have developed unevenly and at a much reduced rate, compared to drug prevention and treatment services. Consequently, there is a clear need to extend the discourse of drug responses to include social reintegration.

Chapter four examines the employment status of problematic drug users in Ireland, how drug users perceive employment and the barriers they experience when trying to improve their chances of finding employment. The key findings to emerge include the following:

- Of cases commencing treatment for problematic drug use in Ireland in 2003, just under 20% were in employment, compared to the national average of 65%, and 61% were unemployed, compared to the national average of 4.6%.
- Drug users who are employed use their main problem drug less frequently and report better drug treatment outcomes than their unemployed counterparts.

Social reintegration *(continued)*

- Drug users view employment as an important part of recovery and do not see methadone maintenance as a barrier to being employed.

Homelessness and drug use are strong indicators of social exclusion. Chapter five presents research from Ireland that shows the levels of social exclusion experienced by homeless drug users. For example:

- In 2003 almost 7% of drug users entering treatment in Ireland were homeless.
- When drug users are homeless they are likely to increase their drug use and progress to patterns of chaotic drug misuse.
- Homeless drug users associate their experiences of emergency hostel accommodation with their more chaotic periods of drug use. They have poorer physical and mental health than homeless people who do not use drugs.

Policy and practice have often been slow in the past to respond to the accommodation needs of homeless drug users. Chapter six presents examples of recent shifts in policy and practice on drugs and homelessness which suggest that the situation is improving. For example, the National Drugs Strategy[6] recognises that the provision of accommodation is an integral element of drug treatment and the 2006 homeless preventative strategy[9] calls on all agencies working on behalf of drug users to work together to improve services.

Vocational rehabilitation is about developing the personal competencies and improving the employability of the recovering drug user. Chapter seven presents the theory behind vocational rehabilitation and chapter eight presents the evidence to show that treatment outcomes can be improved when clients are assisted in developing their vocational skills.

- Evidence suggests that vocational training contributes to a reduction in drug use.
- Completion of vocational programmes is strongly associated with obtaining employment and improved personal and social functioning.
- Supported work interventions and dedicated employment counsellors are effective at getting drug users into employment.
- Evidence from vocational rehabilitation interventions in Ireland suggest that participants have made educational and vocational progress by improving their literacy, achieving accredited training certificates and progressing to work placement and, in some cases, paid employment.

Chapter nine develops the concept of employability and provides a framework for service providers to map the progression of clients in vocational training projects. The main themes to emerge indicate that enhancing employability involves matching the attitudes and capabilities of the individual, the needs and expectations of employers and the demands of the labour market. Enhancing employability for drug users also requires an inter-sectoral partnership approach from service providers, and problematic drug use needs to be brought under control through treatment if recovering drug users are to have a realistic chance of enhancing their employability.

Finally, chapter ten presents a model of social reintegration that predicts the different phases of recovery that drug users can experience. The model developed by Buchanan[10] outlines six phases to social reintegration for problem drug users. The first four phases signal changes in the individual and in their use of drugs as they move from chaos to eventual control. The later three phases suggest that, while recovering drug user's move towards 'normal living', individuals and agencies in the wider society need to change their attitudes and behaviour towards recovering problematic drug users. The model provides a useful framework to conceptualise the symbiotic changes that must take place on the part of the drug user and the wider society, if the vision of social reintegration is to be realised.

The publication of this Overview is timely in that it follows the recently launched report of the Working Group on Drugs Rehabilitation.[11] That report sets out the structural arrangements required to respond to homelessness, inadequate education and poor employment skills among current, stabilised and former users. It is hoped that the evidence presented in this Overview on both the social risks of homelessness and unemployment and the ways in which these risks can be reduced will help to inform the implementation of the rehabilitation strategy.

(Martin Keane)

1. Keane M (2007) *Social reintegration as a response to drug use in Ireland.* Overview 5. Dublin: Health Research Board.
2. United Nations Single Convention on Narcotic Drugs, 1961 (Article 38, sections 1 and 2).
3. Working Party on Drug Abuse (1971) *Report of the working party on drug abuse.* Dublin: Stationery Office.
4. Department of Health (1991) *Government strategy to prevent drug misuse.* Dublin: Department of Health.
5. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996) *First report of the ministerial task force on measures to reduce the demand for drugs.* Dublin: Stationery Office.
6. Department of Tourism, Sport and Recreation (2001) *Building on experience: National Drugs Strategy 2001–2008.* Dublin: Stationery Office.
7. Council of the European Union (2000) *EU Action Plan on Drugs 2000–2004.* Brussels: Council of the European Union.
8. The Alcohol and Drug Research Unit (ADRU) is the Irish Focal Point and reports annually, to the EMCDDA on the drug situation in Ireland.
9. Pillinger J (2006) *Preventing homelessness: a comprehensive preventative strategy to prevent homelessness in Dublin, 2005–2010.* Dublin: Homeless Agency.
10. Buchanan J (2004) Missing links? Problem drug use and social exclusion. *Probation Journal*, 51(4): 387–397.
11. Working Group on Drugs Rehabilitation (2007) *National Drugs Strategy 2001–2008: rehabilitation. Report of the working group on drugs rehabilitation.* Dublin: Department of Community, Rural and Gaeltacht Affairs.

Innovative job placement model for methadone-maintained clients

The *Report of the Working Group on Drugs Rehabilitation*[1] which was compiled to form the basis of the proposed rehabilitation pillar of the National Drugs Strategy recommends that measures to improve the employability of current, former and recovering drug users should form a key part of rehabilitation care plans, with the overall aim 'to maximise the quality of life, re-engagement in independent living and employability of the recovering problem drug user, in line with their aspirations' (p. 21).

The logic of this aspiration to improve employment prospects for individuals affected by the use of drugs is supported by research from the US by Platt,[2] which found that clients in employment stayed in treatment longer and achieved better outcomes than their unemployed counterparts. However, with unemployment rates among treatment contacts remaining high (61% of cases entering treatment in 2003 in Ireland were unemployed[3]), finding ways to improve employment opportunities is a challenge for service providers.

There is no vocational intervention or programme that has been generally adopted for any client population or treatment modality in the addiction field, although some initiatives have been tried, primarily in the US. One such intervention is the Customized Employment Supports (CES) model. This model is a manual-based, theory-driven approach and involves a skilled vocational counsellor working intensively with a small caseload of clients to overcome the vocational and non-vocational barriers to employment. The model comprises individual counselling, rapid job searching and therapeutic fieldwork.

A recent evaluation of this model suggests that it can be an effective approach to improving the employment prospects of methadone clients.[4] This study tested the hypothesis that methadone-maintained clients assigned to the experimental (CES) group would have better employment outcomes than those assigned to a control condition who received standard vocational counselling. The study involved 184 clients at two methadone clinics in New York City. Unemployed or underemployed clients who were stablised on methadone for at least 30 days and who had negative urine tests for heroin and/or cocaine use in the previous four weeks were eligible to take part in the study. Also, an absence of severe mental illness or disability and a willingness to enter the study were required.

Participants were randomly assigned to the CES group or the control group. The research team implemented quality assurance procedures to ensure consistency in the way CES counsellors delivered the intervention and in the way researchers conducted interviews and recorded the data from participants.

Data were collected at baseline and at 6-month and 12-month follow-ups in interviews with participants and from vocational activities logs provided by counsellors and documentation of employment activity. The retention rate at 12-month follow-up was 91% (168/184). The final analytical sample comprised 168 participants, of whom 78 were in the CES group and 90 in the control group.

The results supported the hypothesis that those in the CES group were significantly more likely than those in the control group to obtain any paid employment and informal, 'of the books' employment. However, no significant differences for competitive employment or total earnings were observed between the groups. Competitive employment was defined as full-time work in the labour market, and any paid employment meant part-time and temporary jobs. Informal employment included jobs that were 'of the books' and operated in what may be termed the 'black economy', where clients did not pay tax or qualify for employment-related protections such as pension, annual leave or insurance.

The authors of the study put forward a number of reasons why outcomes for competitive employment were not better. These included:

Clients' reluctance to seek or accept full-time paid employment as this would mean entering a competitive labour market, probably at the rate of minimum wage because of their poor employment histories and lack of skills, with the threat to their eligibility for welfare assistance plus rent supplement, food stamps and medical insurance if they did not succeed in maintaining competitive employment

- Clients' fear at leaving a familiar but unproductive lifestyle and entering the competitive world of work where they would be compared with employees of long-standing in the labour market
- Client's preference for temporary or 'of the books' employment as a way of increasing their ability and confidence to eventually enter the competitive labour market
- A deteriorating job-market during the study period.

Although this study involved relatively small numbers of methadone-maintained clients and the transferability of findings from the US to Europe is not proven, the findings suggest that intensive vocational intervention during treatment can improve employment outcomes.

Finally, in discussing the findings of this study and possible implications for policy and practice, the authors make a number of pertinent points that require further reflection by all stakeholders

Innovative job placement model *(continued)*

interested in the rehabilitation and social reintegration of drug users.

- There is a need for skilled vocational counsellors, located in or near treatment centres, to engage and motivate clients to improve their employability.
- For such interventions to be more widely adopted there has to be a strong belief in the value of client employment among all treatment staff.
- Each job taken on by recovering drug users, no matter how brief, must be valued as a positive learning experience for the client.
- There is a need for research that follows employed substance users over considerable periods of time to determine how much support they need, and for how long. Progressive social policies that promote appropriate incentives for prospective employers to encourage them to hire persons in recovery need to be developed.

(Martin Keane)

1. Working Group on Drugs Rehabilitation (2007) *National Drugs Strategy 2001–2008: Rehabilitation. Report of the working group on drugs rehabilitation.* Dublin: Department of Community, Rural and Gealtacht Affairs.
2. Platt JJ (1995) Vocational rehabilitation of drug abusers. *Psychological Bulletin,* 117(3): 416–433.
3. Keane M (2007) *Social Reintegration as a response to drug use in Ireland.* Overview 5. Dublin: Health Research Board.
4. Magura S, Blankertz L, Madison EM, Friedman E and Gomez A (2007) An innovative job placement model for unemployed methadone patients: a randomized clinical trial. *Substance Use & Misuse,* 42(5): 811–828.

Residential services for alcohol and drug users

The National Drugs Strategy (NDS) 2001–2008 provides the strategic framework for drug services in Ireland. The strategy is based on four pillars, supply reduction, prevention, treatment and research, and is underpinned by 100 actions which are the responsibility of various government departments and agencies. Through the NDS, the Health Service Executive (HSE) (formerly the 10 health boards), is mandated to provide a range of treatment options, including residential components, to drug users experiencing problems.

In 2005, a mid-term review of the NDS recommended that rehabilitation be adopted as a fifth pillar of the Strategy. Arising from this recommendation, the HSE appointed an expert working group in 2006 to describe residential treatment services for problem drug and alcohol users in Ireland, to calculate their current capacity and to estimate future requirements. The report of that group has now been published.[1]

The working group mapped existing inpatient detoxification, rehabilitation and aftercare services, and reviewed the international literature. The literature examined four specific areas: models of care, the evidence base for opiate and alcohol detoxification, methods employed to calculate the number of places required for detoxification, and the standards for measuring quality of care. Available data from existing reporting systems, such as the Hospital In-Patient Enquiry scheme,

Bed type	Current provision	Total beds required	Shortfall
Medical detoxification and stabilisation	23	127, of which: 50% for alcohol (64), and 50% for drugs (63)	104
Community-based residential detoxification	15	Assessment not completed	
Residential rehabilitation	634.5, of which 31% are reserved for use by people with problem alcohol use only	887, of which: between 14 and 37 for a specific adolescent service; 205 for illicit drug users transferring from inpatient detoxification services; 382 for problem alcohol users transferring from inpatient detoxification services; and 300 to address the needs of drug or alcohol users who have attended outpatient detoxification services	252.5
Step-down/halfway house	155, of which 76% are for use by men only	296 (required by 30% of service users)	141

Residential services *(continued)*

the National Drug Treatment Reporting System and the National Psychiatric In-Patient Reporting System, were analysed. A number of submissions were made to the group. A population-based approach was adopted to estimate the level of residential services required. The availability of and requirements for residential treatment beds are shown in the table below.

The key recommendations of the working group are:

- The four-tier model of service delivery, which offers clients the least intensive intervention appropriate to their need, should be adopted as the framework for the future delivery of alcohol and drug services in Ireland. It was acknowledged that the all four tiers need to be fully resourced for this model to be effective.
- A standardised assessment protocol which allows for the systematic identification of each client's needs is required.
- Inpatient detoxification should, as a rule, be provided in dedicated units. The transition from a detoxification programme to rehabilitation should be seamless so as to avoid waiting lists, relapse and (in the case of opiates) overdose. Detoxification must be followed up by rehabilitation and aftercare interventions. The number of inpatient detoxification and residential rehabilitation beds needs to be increased (see table above).
- Where there is unused capacity at present in a service or unit because of staffing shortages, such capacity needs to be brought on stream immediately.
- In highlighting a deficit of 356.5 beds (104 inpatient detoxification and 252.5 rehabilitation), the working group noted the estimated 66 beds in psychiatric units and hospitals that are currently used for alcohol and drug problems and which will no longer be available as a result of the restructuring proposed in the report of the expert group on mental health policy.[2]
- Of the estimated 63 beds required for inpatient detoxification for drug users, one 50-bedded unit should be provided between the Dublin Mid-Leinster and Dublin North East HSE regions where, the data indicate, the majority of opiate and benzodiazepine users live. The remaining 13 beds should be divided between the HSE Southern and HSE Western Regions.
- In the case of services focusing primarily on the treatment of alcohol problems (detoxification and residential), the beds need to be evenly spread over the four HSE regions (16 per region) since the data suggest a more even distribution of alcohol-related problems throughout the country.
- Clients with co-morbidity issues who are in residential drug and alcohol services should be provided with adequate support by the mental health services, with clear pathways into residential mental health services when required.
- There is a need to review community-based or outpatient detoxification services, including the possible role of Level 2 GPs in their provision.
- The Prison Service needs to extend its detoxification and rehabilitation programme in Mountjoy Prison, and establish similar programmes in all other prisons within the State.
- The provision of step-down or halfway-house accommodation for newly released prisoners and homeless people who have been detoxified or who have started rehabilitation programmes is particularly important.
- A unique identifier and mechanism to track progression from treatment services to rehabilitation is required.
- A directory of current residential services needs to be developed and undated annually.
- Families of drug and alcohol users could be more involved in the overall careplans of recovering users. Innovative approaches to care for the children of drug users while in treatment are required.
- The Quality in Alcohol and Drugs Services (QuADS)[3] suite of organisational standards and the Drug and Alcohol National Occupational Standards (DANOS),[4] developed in the UK by Alcohol Concern and Drugscope and Skills for Health, should be adapted for use by drug and alcohol services in Ireland.
- There must be quality standards for the residential facilities themselves, and the HSE should discuss with the Health Information and Quality Authority (HIQA) the possibility of bringing such facilities under the regulation of HIQA's social services inspectorate. This would help avoid duplication of effort when quality audits are undertaken.
- It is particularly important that relevant stakeholders ensure that all detoxification procedures meet the highest standards of clinical governance, care and patient safety.
- The level of provision set out in this report should be reviewed in March 2010.

(Jean Long)

1. O'Gorman A and Corrigan D (2007) *Report of the HSE working group on residential treatment and rehabilitation (substance users).* Dublin: HSE.
2. Expert Group on Mental Health Policy (2006) *A vision for change: report of the expert group on mental health policy.* Dublin: Stationery Office.
3. Alcohol Concern and DrugScope (1999) *Quality in Alcohol and Drug Services (QuADS): Organisational Standards.* London.
4. For more information about DANOS, see the Skills for Health website at www.skillsforhealth.org.uk.

RDTF strategies and prevention

In the last issue of *Drugnet Ireland* the responses of the regional drugs task forces (RDTFs) to the Supply Reduction pillar of the National Drugs Strategy were considered.[1] In this issue, responses under the Prevention pillar are considered.

The National Drugs Strategy recognises four components of Prevention – education, awareness, information, and prevention, the last encompassing support for the family, and diversionary and structural interventions.[2] The strategies of the 10 RDTFs[3] display a similar range of understandings of the concept, but highlight the challenge of choosing the right mix of interventions, and providing them at the right time in the right places. Different elements of this challenge are teased out here. The types of substances being used need to be taken into account. For example, in the north-west, there is a low level of illegal drug use – mostly cannabis and ecstasy – and the principal problems are due to polydrug use, under-age drinking and the extent to which the drug culture and under-age drinking have become intertwined. As a consequence, the RDTF has decided to focus on 'awareness', with two objectives – to raise the levels of awareness of drug misuse and under-age drinking, and to research, compile and disseminate relevant and up-to-date data regarding drug misuse and under-age drinking in the region (NWRDTF: 7).

The age of the target populations and their particular needs also have to be taken into account. One RDTF found that many education/prevention measures were targeting adults (aged over 18), although it was acknowledged that the most vulnerable to developing a drug misuse problem are primarily those under the age of 16 years. The assumption appeared to be that services targeting families and concerned others would equip these individuals to have an influence on their at-risk family members. The RDTF argued: 'The capacity of family members to exert their influence with regard to preventing young people from becoming involved in drugs, or in terms of early identification, may need to be examined to ensure that resources are being deployed in the most efficient and effective manner' (SWRDTF: 37–8).

Another RDTF noted that older age groups had separate and distinctive needs: 'The focus of drug and alcohol campaigns is often on young people and their risk-taking behaviours, yet it is also important to look at the range of people and age groups who may develop problems. While it may be true to say that very few older people develop heroin problems, they may experience difficulties with alcohol, tranquillisers, sleeping tablets or painkillers. It is important to recognise that people may be experiencing dependence difficulties with over-the-counter medications' (WRDTF: 29). Having consulted with education and prevention service providers in its region, the SWRDTF reported, 'There is an almost exclusive focus on education as the primary method of prevention, which is worrying given the correlation between drug misuse and early school-leaving' (SWRDTF: 25). Other preventive measures, such as diversion, might be more relevant to this population.

The location of services and the channels for the provision of prevention services across large regions poses yet another set of challenges. The SWRDTF found wide variations in the range of education/prevention services provided in different settlement areas, with patchy coverage in core urban areas, and progressively lower levels of service provision in sub-urban commuter towns and in rural areas. Conversely, in the ECRDTF it was found that there was an over-supply of education/prevention services in comparison to treatment, harm reduction and rehabilitation services. It was observed that this represented 'a narrow perspective which will need to be widened if the drug problem in the area is to be addressed in any comprehensive or coherent way' (ECRDTF: p. 24). Finding that most services operated on a basis of open access, the ECRDTF suggested this had both advantages and disadvantages: everyone had access to a service but those most in need or those whose needs could best be met by a particular programme might miss out through allocation of places on a first-come – first-served basis. It called for more targeted services, run according to clear aims and objectives, and evaluated to ensure resources are being used efficiently and effectively (ECRDTF: p. 25).

Co-ordination of services across extensive regions and the establishment and maintenance of standards were identified as means of coping with the challenges of providing appropriate services. Proposed actions included:

Regional drugs task force		Catchment area
ECRDTF	East Coast	South Dublin City and County excluding seven LDTF areas, East Wicklow
MRDTF	Midland	Counties Laois, Longford, Offaly, Westmeath
MWRDTF	Mid-Western	Counties Clare, Limerick, North Tipperary
NDRDTF	North Dublin City and County	North Dublin City and County excluding five LDTF areas
NERDTF	North East	Counties Cavan, Louth, Meath, Monaghan
NWRDTF	North West	Counties Donegal, Leitrim, Sligo and north-west Cavan
SRDTF	Southern	Counties Cork, Kerry
SERDTF	South East	Counties Carlow, Kilkenny, South Tipperary, Waterford, Wexford
SWRDTF	South West	South and West Dublin, West Wicklow and County Kildare
WRDTF	Western	Counties Galway, Mayo, Roscommon

RDTF strategies *(continued)*

- appoint a prevention co-ordinator to run a regional education/prevention forum and to research, develop and apply a model of best practice and early intervention;
- set up a regional drugs education forum;
- establish a unified standard across the voluntary, community and statutory sectors within drugs education/prevention;
- increase the level of monitoring and evaluation;
- provide training of personnel as a way of enhancing the standard of services;
- support existing addiction studies courses; and fund the development and delivery of a locally-based diploma in addiction studies in conjunction with local service providers and tertiary educational institutions.

(Brigid Pike)

1. Pike B (2007) RDTF strategies and supply reduction. *Drugnet Ireland,* Issue 23: 4.
2. Department of Tourism, Sport and Recreation (2001) *Building on experience: national drugs strategy 2001–2008.* Dublin: Stationery Office. Section 6.3.
3. The RDTF strategy and action plan documents are held in hard copy in the National Documentation Centre, and are available online at www.hrb.ie/ndc.

Promoting evidence-based practice in drugs task forces

This article reports on the process and outcomes of work by the Alcohol and Drugs Research Unit (ADRU) of the Health Research Board (HRB) in collaboration with the National Drugs Strategy Team (NDST) in promoting good practice in reducing demand for drugs in local and regional drugs task forces.

This work is in response to the following EU and national policy objectives:

- EU Drugs Action Plan 2005–2008 calls on the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and National Focal Points (NFPs)[1] to improve coverage and dissemination of, and access to, evaluated best practice in reducing demand for drugs.
- Action 91 of the National Drugs Strategy calls on the NDST to disseminate models of best practice from the work of local and regional drugs task forces (LDTFs and RDTFs).

From May to July 2007 ADRU, in collaboration with the NDST, ran six workshops with representatives from the drugs task forces. The workshops introduced participants to:

- Evidence-based practice (EBP) in drug prevention
- EBP in rehabilitation and social reintegration as core components in an overall drug treatment response
- the logic-model as a framework for designing good practice interventions

For the purpose of the workshops, EBP was defined as practice based on the findings of scientific research. The examples presented in the workshops were drawn from up-to-date systematic reviews on 'what works'. This facilitated a discussion on the quality and relevance of published research and its usefulness to service providers.

The workshops included a research exercise with representatives from the task forces to establish the following:

- To what extent is evidence from research used when strategic and operational plans are compiled?
- What are the perceptions of and barriers to using research evidence?
- How can the use of research evidence to inform policy and practice be supported in the future?

Data were collected through focus groups with nine regional drug co-ordinators, 15 development workers and a group of 10 people that included community liaison workers, project managers, RDTF community and voluntary representatives, and an RDTF chairperson.

The main findings from the focus groups were:

- Regional and local drugs task forces, for the most part, have not used research to inform the development of their strategic response to drug use and associated problems.
- The main obstacles to using an evidence-based approach appear to be cultural, with communities perceiving research as belonging to a different culture, that of the 'ivory tower' of academia, and having little relevance or application to the services being developed in communities.
- This perceived cultural gap between research and practice in the communities often results in fear among service providers of engaging with

Evidence-based practice *(continued)*

research, which is often seen as complex and inconclusive

- Services are usually planned using what was reported as 'a top of the head approach' – a mix of anecdotal evidence and personal experience – when deciding the most effective way to respond to a particular problem.

However, the focus groups also revealed a willingness to engage with and use research evidence to inform practice if the appropriate supports were in place. It was also felt that task force committees and sub-groups could be persuaded of the value of engaging with and using research evidence if the following measures were adopted:

- Take research out of the perceived 'ivory tower' of research institutions and make it understandable and relevant to service providers.
- Make research evidence available to communities in an accessible format that does not involve having to sift through cumbersome research reports.
- Present research evidence in a way that allows service providers to assess the implications for their services.
- Support communities with regular training and education workshops and give service providers quality follow-up support.

In early September 2007, the outcomes from the workshops were presented to the NDST, with recommendations to promote and develop an evidence-based culture in the drugs task forces. The recommendations were:

- Design and run workshops on EBP, targeting task force committees (and then services).
- Explore mechanisms to adopt and implement EBP with task force committees.
- Identify and facilitate the use of evaluation techniques to assess the effectiveness of an evidence-based approach to service delivery.
- Provide technical assistance to task forces to enable them to design and implement small area studies that estimate the extent of drug use, and quality assessment criteria for interventions.
- Liaise with service providers to identity information needs on 'what works' in identified areas.
- Produce regular and up-to-date bulletins on EBP in specific domains, for example, school based prevention, selective prevention, and family support

These recommendations are in line with the main outcomes from the focus groups, which identified a cultural gap between research and local practice. Consequently, there a need to try to bridge this gap using a staged approach to supporting local communities to shift from a 'top of the head' approach to the use of research evidence. The recommendations are also in line with the four main outcomes identified by Proctor[2] that must be attained if EBPs are to be successfully adopted by practitioners:

1. Motivate and facilitate agency-based practitioners to identify and access information about available EBPs that have been identified by others.
2. Identify approaches to bring about acceptance of EBPs and facilitate adoption once identified and accepted.
3. Identify methods that facilitate specific implementation of EBPs, for example, manuals, incentives.
4. Identify methods to facilitate the evaluation of outcomes following implementation to permit feedback and revision.

ADRU, in collaboration with the NDST, will continue to play a role in disseminating EBP to service providers in the regional and local drugs task forces. This work will be influenced by the 'translational' model of dissemination as advanced by Lawrence.[3] This model is based on the idea of research being translated by 'knowledge brokers', making it policy and practice relevant. This approach is seen as more useful than the traditional linear approach to dissemination, which assumes that, when research evidence is made available, practitioners have the time and interest to read and interpret the results and apply them to practice.

(Martin Keane)

1. The Alcohol and Drug Research Unit (ADRU) is the Irish National Focal Point (NFP) of the EMCDDA.
2. Proctor EK (2004) Leverage points for the implementation of evidence-based practice. *Brief Treatment and Crisis Intervention,* 4(3): 227–242.
3. Lawrence R (2006) Research dissemination: actively bringing the research and policy worlds together. *Evidence and Policy,* 2(3): 373–384.

New law defines Minister's responsibility for National Drugs Strategy

On 9 July 2007 the Community, Rural and Gaeltacht Affairs (Miscellaneous Provisions) Bill 2007 was enacted.[1] The Act provides a coherent statutory mandate for the functions and responsibilities of the Minister for Community, Rural and Gaeltacht Affairs, including:

Co-ordinate the implementation of the National Drugs Strategy (including matters relating to the allocation of services and facilities to counter drug misuse in areas of the State where such misuse is significantly higher than in other areas of the State). (Section 2 (1) (d))

According to Section 2 (2–4) of the Act, the Minister also has the power to develop, implement, maintain, expand or terminate any scheme that in her or his opinion supports or promotes the functions for which he or she is responsible, including the co-ordination of the National Drugs Strategy.

The precise meanings of 'National Drugs Strategy' and 'scheme' are clarified in Section 1 of the Act. 'National Drugs Strategy' is defined as 'national strategies approved from time to time by the Government for the purposes of countering drug misuse in the State'. 'Scheme' is defined as 'programmes or measures operated, managed, delivered or sponsored, whether in whole or in part, directly or indirectly or in conjunction or co-operation with any other person … by the Department in relation to the performance of any of the functions of the Minister'.

With regard to other ministers and organisations with roles and responsibilities for implementing the National Drugs Strategy, Minister Éamon Ó Cuív TD stated: 'It should be noted that section 2 [of the Act] does not seek to limit or assume in any way the powers, functions and responsibilities of other Ministers or State agencies or bodies. Accordingly, there is provision in the Bill for appropriate consultation with other Ministers.'[2]

(Brigid Pike)

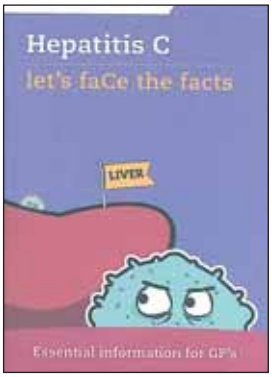
1. Community, Rural and Gaeltacht Affairs (Miscellaneous Provisions) Act 2007. Available at www.gov.ie/oireachtas/frame.htm
2. Ó Cuív É (2007, 3 July) *Parliamentary Debates Dáil Éireann Official Report: Unrevised.* Vol. 637, col. 1246, PDF version. Available at www.gov.ie/oireachtas/frame.htm

Ballyfermot Drugs Task Force hepatitis C campaign

The Ballyfermot Hepatitis C Campaign is being run to raise awareness of hepatitis C and of the options for its investigation and treatment at appropriate services. As part of the campaign, information booklets were published for three different audiences – active drug users, ex-drug users who injected at some time in the past, and GPs caring for people with hepatitis C. Also part of the campaign, the current issue of *d-Talk* is a 'Hepatitis C special'.[1]

Each booklet covers issues specific to the target group, but all include information on who is at risk of acquiring hepatitis C, facts about the infection, symptoms of acute hepatitis C, blood tests and other investigations for diagnosing the illness, possibilities for and improvements in treatment, side effects of treatment and requirements in order to start treatment. The active drug users' booklet has a section on protecting against infection. The ex-drug users' booklet has an expanded section on personal health. The GPs' booklet contains some common beliefs among drug users about hepatitis C, and more detailed information on investigation and treatment.

These booklets present accurate factual information and are useful not only to the immediate target groups but to those living or working with drug users. The booklets can be



shared with other taskforce areas with a high prevalence of drug users.

(Jean Long)

1. The longer we ignore hepatitis C the bigger the problem will get. *d-Talk,* Autumn 2007, Issue 6. (Produced by Ballyfermot Advance, with support from the Ballyfermot LDTF.)

For further information and copies of the booklets, please contact:

Ballyfermot Advance Project
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Dublin 10

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email: info@ballyfermotadvance.ie

Substance misuse in the HSE South Eastern Area

The Health Service Executive (HSE) South Eastern Area published its annual report, *Data co-ordination overview of drug misuse 2006,* in September 2007.[1] The report comprises four sections: recent developments, treatment services, education and prevention, and supply and control.

The section on treatment services analyses data collected from statutory and voluntary drug and alcohol treatment agencies, acute general hospitals and psychiatric hospitals in the HSE South Eastern Area. The data from the drug and alcohol treatment services are returned to the National Drug Treatment Reporting System in the Health Research Board.

The total number of contacts with treatment services in 2006 was 2,641, a decrease of 145 cases on the 2005 figure. The report notes that the decrease was due to a staff vacancy in Carlow, and staff absences on maternity and sick leave in services in other areas. Contacts with treatment services include those by clients continuing in treatment from the previous year, clients who were assessed but not treated, clients who were treated, and concerned persons. Some 115 concerned persons, family members or close friends of substance users, contacted treatment services in the south-east in 2006.

The combined total of new referrals who were treated and clients who returned to treatment after an absence was 1,880. Of these:

- 71% were male and 29% female.
- 8% were under the age of 18, and 44% were aged between 20 and 34.
- Alcohol (67%) was the most common main problem substance for which treatment was sought, followed by cannabis (14%) and heroin (9%).
- The number of clients whose main problem substance was cocaine remained stable at 86.
- Of the 1,022 clients who had used a drug, 80% reported that cannabis was the first drug they had ever used.
- 776 (41%) clients reported using a secondary substance, the main ones being cannabis (347), alcohol (121) and ecstasy (97).
- 60% of clients treated for alcohol and 61% treated for a drug as their main problem substance were treated for the first time.

Of 2,506 clients treated in the south-east in 2006 (including clients continuing in treatment from the previous year), 58 (2%) had injected a substance.

The data presented in this report are useful for planning future services.

(Jean Long)

1. Kidd M (2005) *Data co-ordination overview of drug misuse 2006.* Waterford: HSE South Eastern Area.

Third HBSC study reports findings

The third Irish HBSC (Health Behaviour in School-aged Children) study,[1] conducted in 2006 by the Health Promotion Research Centre in the National University of Ireland, Galway, was published in August 2007. HBSC is a cross-national research study conducted every four years in collaboration with the World Health Organization, and in 2006 there were 41 participating countries and regions. The overall aims of the HBSC are to gain insight into and increase understanding of young people's health and well-being, health behaviours and their social context.

HBSC is a school-based survey with data collected through self-completed questionnaires administered by teachers in the classroom. The sampling frame consisted of primary and post-primary schools. A two-stage process identified study participants: individual schools within regions were first randomly selected, and class groups were then randomly selected for participation. Sixty-three per cent of invited schools and 83% of students sampled participated in the 2006 HBSC survey. Data were collected from 10,334 children aged 10–18 years on topics including general health, smoking, use of alcohol and other substances, food and dietary behaviour, exercise and physical activity, self-care, injuries and bullying. This article describes the results pertaining to the use of alcohol and other substances, and makes comparisons with the previous HBSC surveys.

Overall, 47% of children reported that they had never had an alcoholic drink, up from 40% in 2002 and 31% in 1998. The percentage of girls (52%) reporting that they had never had an alcoholic drink was higher than that for boys (43%), and there was little evidence of a social class effect. This is the only variable that showed a marked change from previous HBSC studies. The proportion of children reporting having had an alcoholic drink in the past month (defined as current drinkers) was 26%. This has remained stable between 2002 and 2006, except in the case of 15–17-year-old boys, where a small decrease is evident.

Children were asked if they had ever been 'really drunk'. In total, 32% of children reported having been drunk, with large age differences but little variation by gender or social class; 5–7% of 10–11-year-olds and 53–58% of 15–17-year-olds reported ever being drunk, with little change since 2002. One in five children reported being drunk in the previous 30 days, with large differences between age groups. Over a third of boys and girls aged 15–17 reported being drunk in the previous 30 days.

This report also studied cannabis use among children. Overall, 16% of children reported using cannabis during their lifetime, compared with 12% in 2002; 12% reported using cannabis in the past 12 months, compared with 11% in 2002. Cannabis use was highest for those aged 15–17,

HBSC study *(continued)*

with about one in five in this age group using cannabis in the previous 12 months. There was little evidence of a social class effect. The rates of reported cannabis use are similar to those in the 2002 HBSC study, except among 15–17-year-old boys, where a decrease is evident.

Seven per cent of children reported using cannabis in the previous 30 days. This was slightly higher for boys (8%) than for girls (5%). Those aged 15–17 were more likely to report recent cannabis use than younger children. A clear social class effect was evident among 15–17-year-old boys regarding recent cannabis use; 10% of boys in the highest social class grouping reported recent cannabis use compared to 15% in the lowest social class grouping.

In conclusion, there was little marked change between 2002 and 2006 in reported alcohol and cannabis use, except in the percentage that had never had an alcoholic drink, which increased over the period. In general, there appeared to be little evidence of a social class effect, except in the case of cannabis use in boys aged 15–17 years. Similarly, there were few gender differences, except in the case of children who had never had an alcoholic drink.

(Deirdre Mongan)

1. Nic Gabhainn S, Kelly C and Molcho M (2007) *The Irish Health Behaviour in School-aged Children (HBSC) study 2006.* Dublin: Department of Health and Children.

Coolmine Therapeutic Community annual report 2006

Coolmine Therapeutic Community was established in 1973. Its mission is to 'provide the best quality residential and community services possible, in order to empower people to end their dependence on drugs and alcohol and to help them realise their right and potential to become participating and valued members of society.'[1] Coolmine's facilities are located in the Dublin area, but they offer a service country-wide. *A year of change: annual report 2006* was published in October 2007.[2]

According to the report, Coolmine has incorporated the Homeless Agency's holistic needs assessment in their case-management system to ensure that all of their clients' needs are taken into consideration. The organisation is committed to providing a 'continuum of care', and in 2006 they launched two new initiatives: the Welcome Programme and the Integration and Aftercare Service.

- The Welcome Programme, based at 112 Cork Street, Dublin 8, provides a tailor-made programme of care for clients who are struggling to become and/or remain drug free. The programme includes counselling, group work, support in accessing accommodation, guidance on detoxification options and introduction to the most appropriate service providers. It can cater for a maximum of 12 clients at any one time. This programme was accessed by 65 clients in 2006, of whom 18 had achieved their planned goals by the end of the year.
- The Integration and Aftercare Service provides support to clients as they negotiate the transition from treatment back into the community, and provides step-down, community-based housing for a minimum of six months. In 2006, the programme provided services to 36 clients.

Coolmine also provides the following services:

- Outreach Services, based at 19 Lord Edward Street, provide a 9am–5pm drop-in facility, along with an outreach service to a number of prisons and homeless services in Dublin city and the midlands. In 2006, the outreach workers assessed 393 people in the community, of whom 140 entered one of the Coolmine services; they also assessed 129 people in prison, of whom 33 entered a community-based service. Coolmine staff also provided 51 group counselling sessions in 2006 for clients who completed the detoxification programme at the Mountjoy Prison Medical Unit.
- The Drug Free Day Programme, also based at Lord Edward Street, provides a six-month, abstinence-based, rehabilitative programme for 12 clients at any one time. In 2006, 27 clients participated in the programme, nine of whom progressed to aftercare and integration services. The programme provides a safe environment where clients can develop skills for a drug-free and independent way of life.
- The Women's Residential Service at Ashleigh House, Clonee, Co Meath, offers women a safe environment in which to address substance use issues and associated behaviours. This six-month programme accommodates a maximum of eight women at any one time, with plans to increase this number to 12 in 2007. There were 17 admissions during 2006.
- The Men's Residential Service at Coolmine Lodge, Grove Road, Clonsilla, gives clients the support and opportunity to tackle and overcome drug dependency and its associated behaviours. The nine-month programme can cater for up to 30 men at any one time. There were 74 admissions during 2006.
- Family Support Services engaged a dedicated staff member in 2006 to work with families and significant others in crisis and to facilitate weekly support groups.

The priorities for Coolmine in 2007 are to increase staffing levels and staff–client ratios in all services, provide crèche and child-care facilities in the women's service, and provide a step-down and aftercare facility for those attending services in Cork city and county.

(Anne Marie Carew)

1. See the Coolmine Therapeutic Community website at www.coolminetc.ie.
2. Coolmine Therapeutic Community (2007) *A year of change: annual report 2006.* Dublin: Coolmine Therapeutic Community.

Help and advice on coping with the death of someone close

In its vision statement and guiding principles, the National Strategy on Suicide Prevention 2005–2014 proposed that 'those affected by a suicide death or deliberate self-harm receive the most caring and helpful response possible'.[1] To assist this process, the strategy proposed a review of the existing information and resources available to the bereaved. In response, the National Office for Suicide Prevention has published the two booklets outlined below.

You are not alone: help and advice on coping with the death of someone close provides practical advice and support to those who have been affected by suicide or an unexpected death.[2] The booklet is divided into five sections: immediate reactions; natural responses; events that occur following a death; sorting out your affairs; and getting help for you and your family. Each section deals with the different stages of the bereavement process.

Immediate reactions and **natural responses** recognise that the circumstances surrounding suicide can be overwhelming and difficult to understand. The aim of these sections is to guide the bereaved through their feelings of anger, guilt and depression both in the initial stages and in the months following the death. The second of the sections addresses the behaviour and emotions that can be expected from a child who has lost a parent, sibling or loved one. It provides ways of breaking the news to a child and methods to keep channels of communication open.

When a death occurs by suicide or is unexpected, certain legal procedures must be followed. **Events that occur following the death** introduces and describes the role of all the parties involved following the death, including that of the gardai and the coroner. The term and process of a post-mortem and its effect on funeral arrangements are explained. Due to the nature of a suicide death, an inquest will be held and a brief description of the inquest proceedings is given. This can delay the issuing of a death certificate, but again an explanation is given on how to obtain an interim certificate from the coroner.

Sorting out your affairs addresses money matters, such as how to access social welfare entitlements and funds lodged in banks, post offices, or insurance policies. Advice is provided on registering a death, who deals with a will or what do in the absence of a will. The terms 'intestacy', 'probate', 'executors' and 'administrators' are explained.

The final section, **getting help for you and your family**, lists the types of support that are available and mentions how people are referred to the mental health services in Ireland.

You are not alone: directory of bereavement support services 2007 is a guide to bereavement support services available throughout Ireland.[3] Specific support services for those who are bereaved due to suicide are highlighted. The booklet provides contact details for multi-branch organisations, including Barnardos Bereavement Counselling for Children, Samaritans and Console. The directory includes voluntary, community-based and self-help groups, and private counsellors.

The role of the HSE Resource Officer for Suicide Prevention is to guide bereaved people to the most appropriate support service available, and to support the service providers. Contact details for the resource officers throughout Ireland are listed, as are key contacts such as ISPCC, GROW and Aware. Irish and international websites are also listed, along with suggested reading.

These booklets will be useful to those who are bereaved, particularly by suicide or sudden death. They have been distributed to GPs, funeral directors, gardaí, resource officers and registered counsellors, and can be downloaded from www.nosp.ie. Further information is available from the National Office for Suicide Prevention, Dr Steevens' Hospital, Kilmainham, Dublin 8. Tel: 635 2179; Email: info@nosp.ie.

(Simone Walsh)

1. Health Service Executive, National Suicide Review Group and Department of Health and Children (2005) *Reach out: national strategy for action on suicide prevention 2005–2014.* Dublin: Health Service Executive.
2. Health Service Executive (2007) *You are not alone: help and advice on coping with the death of someone close.* Dublin: National Office for Suicide Prevention.
3. Health Service Executive (2007) *You are not alone: directory of bereavement support services 2007.* Dublin: National Office for Suicide Prevention.

Crosscare Teen Counselling annual report 2006

The 2006 annual report from the Crosscare Teen Counselling service was published recently.[1] The report brings together information from the five teen counselling centres operated by Crosscare in Dublin. The overall aim of the counselling service is to enable young people and their parents or carers deal with family conflict, mental health, substance use and behavioural issues among teenagers within the context of the family. The service saw 400 families in 2006, which included 248 new cases and 152 cases carried forward from 2005. Of the new cases, 44% of teenagers were living with both biological parents and 85% were in secondary school. Sixty-seven per cent of new teenage clients were aged under 16 and 55% of these were female. Fifty per cent of new teenage clients reported drinking alcohol and 23% reported using a drug other than alcohol, with cannabis (17%) the most popular.

The report includes results from an internal evaluation of the service in 2006 based on four strands:

1. Parents were asked to assess the severity of problems they were experiencing and their ability to deal with them at baseline and again when therapy was completed. Sixty-five per cent of parents who completed this process reported a great reduction in the severity of problems and 34% reported some reduction. Fifty-four per cent said their ability to cope had greatly improved and 45% said there was some improvement.
2. Teenagers were asked to assess the severity of their difficulties at baseline and again when therapy was completed across four domains: at home, in school, among friends and self. Improvement was reported in all domains, with 96% reporting improvement in relation to problems they attributed to self. (Table 1).
3. Counsellors evaluated all cases that had completed therapy in 2006 (n=256) on the severity of problems that they presented with and their underlying problems. Thirty-nine per cent reported improvement in the problems families presented with and 44% reported improvement in the underlying problems.
4. Counsellors used the Global Assessment of Relationships Functioning DSM-IV to measure family functioning at baseline and again at therapy completion. When therapy had completed the average for family functioning was scored at 87, an increase from 56 at baseline. Higher scores are indicators of improved functioning among families.

Counsellors used the Global Assessment of Functioning DSM-IV to assess how well teenagers were functioning at baseline and again when therapy was completed. On completion, the average score was 69, an increase from 58 at baseline, indicating that some improvement had occurred.

However, the results of this evaluation must be treated with a degree of caution as it cannot be definitively shown that the improvements reported by participants and staff were due to the intervention because the evaluation did not control for competing explanations. For example, the severity of problems could have reduced with the passage of time and the capacity of parents/teenagers to cope with problems could have improved with time, without either being affected by the intervention. Given that families received counselling for an average of nine months, the issue of time is important. One way that the evaluation could have controlled for this competing explanation would have been to compare parents and teenagers receiving the intervention (experimentals) with a group of similar parents/teenagers on the waiting list for the intervention (controls). The report notes that 41% of referrals to the programme in 2006 were placed on a waiting list.

Despite the limitations of the evaluation design, it would appear that the Teen Counselling service provides a much-needed response to families in distress and is well regarded by professionals. The majority of referrals to the service were by schools, family doctors, psychologists, counsellors, social workers and health professionals. Engaging and maintaining participants in counselling presents challenges to service providers targeting 'at risk' families. The report notes that including parents in the work and providing a locally based service that is not stigmatised are key elements in the success of the service.

(Martin Keane)

1 Teen Counselling (2007) *Teen Counselling annual report 2006.* Dublin: Crosscare.

Table 1 Percentage of teenagers reporting improvement following therapeutic intervention

	Greatly improved (%)	Improved (%)	No change (%)
Home	22	50	28
School	13	60	23
Friends	30	30	40
Self	38	58	4

Source: Teen Counselling (2007)

Focus on methamphetamine

The Garda National Drugs Unit recently undertook a project in partnership with the UK and Sweden, and funded by the AGIS programme, which examined the potential threat posed by the increased incidence of methamphetamine use throughout the EU, and remedies undertaken to date by respective agencies, including law enforcement, forensic science and customs services. As part of the project, study visits to centres of expertise in partner and participating countries took place between March and October 2007, and a uniform questionnaire was completed in 10 countries to elicit relevant information.

The project culminated in an international conference in the Nuremore Hotel, Co Monaghan, from 26 to 28 November 2007. The aim of the conference was 'to establish a threat assessment for the increase in availability of methamphetamine within the European Union'. The seminar was launched by Assistant Garda Commissioner Martin Donnellan. Throughout the three-day conference, presentations were given on:

- the role of Eurojust in the fight against serious cross-border and organised crime
- UK and US perspectives on methamphetamine
- a Swedish perspective on methamphetamine in the Nordic region

A series of workshops discussed the following topics:

- Observations on methamphetamine abuse and the threat which it poses within the EU
- Legal frameworks on the control of illegal drugs and the need to have sufficient, modern legislation concentrated on illegal drug controls
- International and interagency co-operation and the need for law enforcement agencies to have a professional and organised approach to co-operation between agencies
- The role of forensic science laboratories in helping law enforcement personnel to combat the threat of methamphetamine
- Synthetic drug laboratories, and the amount of expertise, knowledge and equipment required by law enforcement personnel to safely identify, investigate and dismantle them
- Drug treatment policies and the range of health and socio-economic harms that synthetic drug abuse poses to users and society.

Recommendations emerging from the workshops called for the regulation of precursor chemicals used in the production of synthetic drugs; protocols to deal with laboratories, including health and safety and enforcement issues; EU-shared profiling of precursor chemicals involved in synthetic drug synthesis; a standardised approach to the forensic analysis of precursor chemicals; and a co-ordinated EU framework to tackle the needs of law enforcement agencies in the fight against methamphetamine. A full report on the conference is due in early 2008.

(Lorraine Coleman and Johnny Connolly)

2007 report on the drugs problem in Europe

Heroin use and drug injecting have become 'generally less common', and cannabis use may be stabilising, according to the *Annual Report 2007: the state of the drugs problem in Europe,* published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in November.[1] However, the level of drug-related deaths remains high and the use of cocaine is increasing. Irish data for the report are provided by the Alcohol and Drugs Research Unit of the HRB.

Cocaine

Cocaine remains Europe's second most commonly used illicit drug, after cannabis. The EMCDDA estimates that 12 million European adults (aged 15–64) have tried cocaine, and 4.5 million have used it in the last year. Most countries reported increases in last-year usage among young adults (aged 15–34). However, slight increases in countries with the highest prevalence — Spain and the UK — suggest that prevalence may be levelling off. Cocaine accounts for 13% of cases entering treatment across the EU and is the most common reason for entering treatment, after opiates (mainly heroin), and cannabis. A total of 22% of new cases entering treatment in 2005 were cocaine related. The number of new clients rose from 12,633 in 1999 to 33,027 in 2005, an indication of the impact on public health. In 2005 a record 107 tonnes of cocaine were seized, up over 45% on quantities seized in 2004.

In Ireland cocaine is the third most commonly used illicit drug, after cannabis and ecstasy and was the third most common reason for entering treatment, after opiates and cannabis. According to the most recent general population survey, 3% of Irish adults (aged 15–64) had used cocaine at some point in their lives; just over 1% had used it in the year before the survey. Just under 3% of young adults (aged 15–34) had used cocaine in the last year, while the European average was almost 2.5%.

Cannabis

Cannabis remains the most commonly consumed illicit drug in Europe. Nearly a quarter of all Europeans have used it at some point in their lives and 7% have used it in the past year. Almost a quarter of young adults had used cannabis in their lifetime, and 9% had used it in the past year. Latest data suggest that cannabis use is now stabilising or falling, particularly in high-prevalence countries. An estimated 1% of European adults — around 3 million people — may be using the drug on a daily, or almost daily, basis and the EMCDDA intends to focus on improving monitoring of this pattern of intensive consumption.

Drugs in Europe *(continued)*

There is no available evidence to determine trends in cannabis use among the general population in Ireland. The 2003 survey reported that one in five adults had used cannabis at some point in their lives and one in twenty had used it in the year before the survey. A quarter of young adults had used cannabis in their lifetime, and 9% had used it in the past year. One in five cases entering treatment in 2006 reported cannabis as their main problem drug.

Injecting drug use and blood-borne infections

Although injecting drug use has become less important as a route of HIV infection, the EMCDDA estimates that it accounted for 3,500 new cases of HIV in the EU during 2005. Hepatitis C Virus (HCV) is more prevalent than HIV among injecting drug users and it is more evenly distributed. In contrast to their success in preventing HIV infection, prevention and harm reduction services seem to be having a weaker impact on preventing HCV. Seven in every ten injecting drug users in Ireland test positive for the hepatitis C virus. Ireland is currently defined as a high-prevalence country for this disease. One in ten injecting drug users in treatment is HIV positive.

Drug-related deaths

The EMMCDA reports historically high levels of drug-related deaths. Between 7,000 and 8,000 people died as a result of drug use in 2005. The downward trend in drug-related deaths between 1999 and 2002 began to reverse in 2003 and has accelerated since then. 'There is an urgent need to research why drug-related deaths remain so high', said EMCDDA Director Wolfgang Götz.

Drug use and related problems among very young people

Illicit drug use among under-15s is rare in Europe, and children account for less than 1% of all treatment clients. Regular drug use among this group is extremely rare and is associated with specific groups in the population where there is a combination of psychological and social problems. Cannabis is the most common illicit substance used among this age group, followed by inhalants (glue and aerosols). Between 5% and 36% of school students have been drunk at least once by the age of 13, and between 7% and 18% have smoked tobacco.

The situation in Ireland closely reflects findings reported across Europe, in prevalence, treatment figures and the most common drugs used. The National Health Behaviour in School-aged Children survey indicates that the proportion of boys aged 12–14 who reported using cannabis in the 12 months prior to the survey decreased from 11% in 1998 to 7% in 2006. Almost one-quarter (24%) of Irish children reporting having been drunk by the age of 13.

Drugs and driving

After alcohol, cannabis and benzodiazepines are the psychoactive substances most prevalent among the European driving population. Many countries have responded by tightening laws, increasing penalties or altering national strategies to address drugs and driving problems. Responses vary greatly, from zero tolerance (sanctioning detection of the substance per se) to impairment laws (sanctioning if a person is deemed fit to drive).

The main evidence in relation to drugs and driving in Ireland comes from a nationwide survey conducted by the Medical Bureau of Road Safety in 2000–2001. The survey found that 68% of drivers tested who had zero levels of alcohol were positive for more than one drug. Legislation allowing random breath testing for alcohol was introduced in Ireland in July 2006. Since then there has been a decrease of 19% in road accidents and a total of 17,788 drink-driving arrests.

(Brian Galvin)

1. EMCDDA (2007) *Annual Report 2007: the state of the drugs problem in Europe.* Luxembourg: Office for Official Publications of the European Communities. www.emcdda.europa.eu/

EU to fund drug prevention and information initiatives

In September 2007 the European Union established a Drug Prevention and Information programme for the period 2007-2013, with a budget of €21.35 million spread over seven years.[1] The European Commission plans to issue the first call for proposals for action grants in December 2007, and the work programme for 2008, with a budget of €3 million, will be announced in January. Further details, including eligibility criteria, can be found in the *OJEU*.[2]

The Drug Prevention and Information programme builds on the EU Drugs Strategy and Action Plan, the ultimate aim of which is to significantly reduce the social harm and health damage caused by the use of, and trade in, illicit drugs. The general objectives of the programme are:

- to prevent and reduce drug use, dependence and drug-related harms;
- to contribute to the improvement of information on the effects of drug use;
- to support the implementation of the EU Drugs Strategy.

The Programme supports projects and activities associated with three specific objectives:

1. to promote transnational actions to:
   - set up multidisciplinary networks that can make a clear and specific contribution to achieving the objectives of this programme;
   - ensure the expansion of the knowledge base, the exchange of information and the identification and dissemination of good practice, e.g. through training, study visits and staff exchanges;
   - raise awareness of the social and health problems caused by drug use and to encourage an open dialogue with a view to promoting a better understanding of the drug phenomenon; and
   - support measures aimed at preventing drug use, reducing drug-related harm, and treatment, taking into account the latest state of scientific knowledge;

EU to fund initiatives *(continued)*

2. to involve civil society in the implementation and development of the EU Drugs Strategy and Action Plans; and
3. to monitor, implement and evaluate the implementation of specific actions under the Action Plans 2005–2008 and 2009–2012.

The target groups of the programme's activities are all those who may be affected by the consequences of drug use, including young people, pregnant women, vulnerable groups and problematic neighbourhoods. Other target groups are: teachers and educational staff, parents, social workers, local and national authorities, medical and paramedical staff, judicial staff, law enforcement and penitentiary authorities, NGOs, trade unions and religious communities. These groups are also potential beneficiaries of the programme.

The Drug Prevention and Information programme is just one of five instruments contained in the framework programme 'Fundamental Rights and Justice', which aims to promote the development of a European society based on EU citizenship and which is respectful of fundamental rights. In turn, this framework programme, together with the EU Drugs Strategy and Action Plan, forms part of the Hague Programme, which sets out the EU's overall objectives in the area of freedom, security and justice in the period 2005–2010.

(Brigid Pike)

1. Decision No 1150/2007/EC of the European Parliament and the Council, 25 September 2007.
2. *Official Journal of the European Union,* 3 October 2007, L 257/23–29.

Civil Society Forum on Drugs in the EU due to meet

The first meeting of the Civil Society (CS) Forum on Drugs in the EU will take place in Brussels on 13 and 14 December 2007. Two Irish-based civil society organisations, and one Irish-based Europe-wide network, are among the 26 networks and organisations invited to participate:

- CityWide Drugs Crisis Campaign www.citywide.ie
- Drug Policy Action Group www.drugpolicy.ie
- Eurad www.eurad.net

It is expected that at this preliminary meeting rules and procedures for the operation of the Forum will be discussed and agreed between the European Commission and CS representatives.

A report published earlier this year by the Commission[1] outlined the direction and shape that the Commission envisages for this Forum. In the report the Commission proposed the following mission statement:

> The Civil Society Forum on Drugs will serve as a platform for informal exchanges of views and information between the Commission and civil society organisations in the EU, candidate countries and, as appropriate, European Neighbourhood Policy countries. The aim is to increase informal consultation and the input of civil society on drug-related activities, policy proposals, policy implementation and priorities of the EU Drugs Strategy and the EU Action Plan on Drugs.

The Commission proposed that the Forum should take full account of the six main conclusions from the open consultation on the Green Paper on the role of civil society in drugs policy in the EU:

1. The Forum should represent a wide spectrum of views in a balanced way.
2. The Forum should be inclusive rather than exclusive, with transparent selection criteria.
3. The Forum should have a clear mandate, well defined agendas, transparent procedures and achievable work plans with real input into the policymaking process.
4. The Forum should be able to ensure continuity of the work and at the same time be flexible enough to adapt to changing CS and policy challenges.
5. The Forum should have adequate financial and human resources.
6. Thematic networks could be organised as subgroups of the Forum or separately.

Membership criteria for the Forum were proposed as follows:

1. The organisation has to correspond to the concept of civil society as set out in the Green Paper.
2. The organisation has to have its main base of operation in an EU member state or a candidate country. Organisations from European Neighbourhood Policy countries may also participate, when appropriate.
3. Priority will be given to those organisations that are established in the form of transnational networks covering a number of member states and/or candidate countries.The organisation has to have drug-related activities as the core focus of it activities.
4. Credibility: The organisation should have a clear track record of its activity.
5. Representativeness: The organisation should be recognised as being able to speak on behalf of those it claims to represent.
6. The organisation must be legal and registered in a member state or candidate country.
7. Membership of the organisation must be open to those that meet transparent criteria and the organisation must be financially accountable.

Finally, the Commission recommended that membership should be for a period of two years, and renewable, to ensure both flexibility and continuity. The maximum size of the Forum should be 30 members.

(Brigid Pike)

1. Report on the results of the open consultation: Green Paper on the role of civil society in drugs policy in the European Union. (COM (2006) 316 final). European Commission, Brussels, 18 April 2007. For more information on the Green Paper, see Pike B (2006) Civil society to have role in EU drugs policy. *Drugnet Ireland,* Issue 19: 19–20.

Minister's contribution to Trinity cannabis debate

In its opening debate of the current academic year, the Trinity College Historical Society debated the motion 'That the sale of cannabis should be legalised'. Speaking in favour of the motion were Senator Ivana Bacik, Reid Professor of Criminal Law at TCD, and Dr Paul Quigley of the Drug Policy Action Group. Opposing the motion were Pat Carey TD, Minister of State for the national drugs strategy, and Johnny Connolly, research officer with the Health Research Board.

Minister Carey set out in some detail the government's position on this controversial issue. With regard to the health effects of cannabis use, the Minister argued that cannabis cigarettes produced 'three times more carcinogenic "tars" than tobacco and five times more poisonous carbon monoxide' and that this put users at risk 'of bronchitis and double(d) the risk of certain types of cancer, including lung and throat cancer'. Referring to the association between cannabis use and mental illness, the Minister stated that long-term cannabis use could, in some cases, 'trigger mental illness such as schizophrenia and depression – two sicknesses that cannot afford to be promoted considering this country's intolerable suicide rates'.

It is often argued that cannabis operates as a so-called 'gateway' to other illicit drugs. The Minister stated that the 'vast majority' of young people who have used a variety of illegal substances initiated their illicit drug consumption with cannabis. Consequently, 'they become involved and immersed in the drug culture', come to know drug dealers and 'more often then not' come into contact with users of drugs of a more serious nature.

With regard to the potency of cannabis, the Minister suggested that, while previously most cannabis contained approximately 2% of the active substance THC, newer 'specially cultivated strains of cannabis can be up to 16% THC'. He acknowledged, however, that these 'newer strains' are not the most commonly used types of cannabis in Ireland. The Minister, who is a former schoolteacher, highlighted research which, he said, pointed to a connection between cannabis use and early school leaving. While cannabis use is, Minister Carey stated, 'far from the only factor stopping teenagers and young adults reaching their educational potential, it seems somewhat ridiculous to me that we would risk further exacerbating the already existing difficulties by legalising cannabis.'

With regard to the reclassification of cannabis to a Class C drug in the UK, the Minister stated that:

> equivalent penalties continue to be much higher than those currently in force in this country. The changes in the UK appear to allow greater discretion in dealing with people found to be in possession of cannabis. Under Irish law, the Gardaí and the Courts already have a very high degree of discretion in dealing with these cases. Furthermore, Jack Straw, UK Secretary of State, indicated recently that he personally was in favour of reclassifying cannabis to a Class B drug.

Referring to developments in the Netherlands, the Minister said:

> The Mayor of Rotterdam recently announced that 27 of its 62 coffee shops must close as of January 1, 2009, because these shops are located too close to secondary and vocational schools. This is part of a rowing back to a degree by Holland at both national and at local level of its existing perceived 'liberal' policy. The relative toleration of cannabis use there is down to a wholly pragmatic view based on their so-called 'gedogen' principle. This principle reflects an ambivalence with respect to whether the drug should be legal or illegal. It is used in relation to a situation or activity that technically is illegal, but which is actively tolerated as a matter of government policy – since everyone knows the issue (say prostitution or the use of soft drugs) can not be legislated out of existence. However, along with this tolerance, there is a relatively hard line taken, with licences for new coffee shops being rarely given and many municipal governments following a so-called extinction policy. The number of 'coffee shops' in Holland has reduced from 1,500 in 1995 to approximately 700 now.

The Minister argued that, although the level of acceptance of cannabis use is growing, 'the majority of people in Ireland… are against the legalisation of cannabis. This is a fundamental reason in a democracy as to why you wouldn't legalise a drug.' Finally, the Minister questioned the assertion that legalisation would result in the elimination of criminal activity surrounding cannabis. 'It may', he argued 'only result in a transfer from drug related criminal activity to other forms of criminal activity.' Even if cannabis were legalised, he suggested, 'it is difficult to envisage that its provision would be anything other than heavily regulated. This would provide continued opportunities for criminals to continue their involvement in the illegal supply of cannabis.'

The motion was defeated by a narrow majority.

(Johnny Connolly)

Recordings of all the speakers' contributions are available as MP3 files on the College Historical Society website at www.thehist.com. Go to **Michaelmas Debates**, Select **Oct 3: Cannabis**, then select **Recordings**.

The Irish Drug Treatment Court – a view from the bench

A European conference on quasi-coerced treatment and other alternatives to imprisonment, organised by the Council of Europe Pompidou Group and the Romanian National Anti-Drug Agency, took place in Bucharest, Romania, on 11–12 October. Below is an edited version of the presentation made by Judge Bridget Reilly of the Irish Drug Treatment Court (DTC).

Judge Reilly was appointed to the DTC in 2001. Introducing her paper, she said: 'I have viewed the awful cycle of drug abuse – offending – imprisonment – release – drug abuse – offending – imprisonment, and was struck with a realisation of the hopelessness and ineffectiveness of the situation. The cycle is self-perpetuating and in turn influences a wider pool, a new generation, increasingly in larger numbers and with more and more associated and serious violence. It seemed obvious that imprisonment failed to break the cycle or to act as a deterrent to further offending. Ultimately the interests of the public at large are not met and trust in, and collaboration with, the criminal justice system is undermined.'

Background

The DTC, established as a permanent court in 2006 after a five-year pilot phase, deals with offenders who have either pleaded guilty or been convicted of minor crimes committed as a consequence of drug abuse. Referral to the DTC is with the consent of the defendant and may be made at the request of the defence or a probation officer, or at the discretion of the presiding judge. At present, such offenders must have resided for a minimum of six months in the Dublin North Inner City area, an area which has suffered a particularly severe drug abuse problem.

The primary aim and purpose of the court is 'the reduction of crime through rehabilitation of the offender but not excluding punishment should the circumstances so warrant'.[1] The DTC is a full criminal court, but operates differently from any other court in that the offender is obliged to comply with terms of a programme tailored to his or her requirements and circumstances. A multi-agency team, monitored regularly by the judge, and comprising a court co-ordinator, probation officer, Garda officer, clinical health nurse and an education officer, delivers this programme. Unlike many other jurisdictions, the Irish DTC includes an education element in the rehabilitation process.

The role of the judge in the DTC

The experience of drug courts internationally has highlighted the role of the judge in the whole process. In the DTC the judge monitors the progress of the participants on the programme and provides leadership, motivation and enforcement and imposes sanctions. The team meets with the defendant at a pre-court meeting. In the early stages of the programme the defendant appears in court every week but this is reduced as s/he progresses through three separate phases. At the hearing in open court there is direct dialogue between the offender and the bench. The participant often volunteers a written submission to explain his/her position. Over time a full picture of the participant becomes apparent to the court. Through continued interaction between judge and participant, a relationship develops and it is important that the participants appear regularly in front of the same judge. However a judge cannot sit for 52 weeks of the year and so the President of the District Court has appointed two other judges to sit in the DTC. In this way the essential consistency and continuation of judicial input should be maintained and the energy, interest and skill of these judges can help in the development of all aspects of the court's work.

Sanctions and incentives

Following the pre-court meeting and appearance in open court the Court proceeds to make its order. The court uses a 'carrot and stick' approach to encourage and reward progress, compliance and engagement with the programme and to sanction failure to comply. The ultimate sanction, and one of last resort, is an order terminating the offender's participation on the programme. A number of lesser sanctions are also available to the judge.

The judge has to draw a balance between support, encouragement and sanctions. This will depend on the character, personality, ability and endeavours of the participant and, indeed, on his/her mood or vulnerability. My own experience accords with research findings which suggest that verbal praise is the most valuable currency. One must always be aware too that other participants present are watching and learning how the system works. They are also assessing how others are being treated so that the system must be, and must be perceived to be, enforced properly and fairly.

Assessing outcomes

Participants graduate when, at the end of Phase 3, they are drug free, have not re-offended and have complied with the obligations of each phase of the programme. At that time, all charges against them are struck out, with liberty to re-enter within 12 months if there are any breaches of ongoing obligations as set out in their life plan prepared for graduation.

It should be noted that all but one of the 88 charges shown in Table 1 were incurred in the initial phase of the three-phase programme. Despite the low graduation numbers, the progress and improvement in quality of life for the participants is seen to be very significant by the DTC team, considering the background of low literacy skills, low educational participation, and often difficult

Irish drug treatment court *(continued)*

social and family history. The court is considering an alternative grading process so as to validate the success or quasi-success of participants who do not attain full graduation criteria, while being aware of how this could affect the motivation of participants to graduate fully.

Table 1 Criminal charges incurred by participants in the DTC in March 2005

Total charges incurred prior to referral to the DTC	518
Total charges incurred during the DTC programme	88

Source: An Garda Síochána, March 2005

A personal observation

In Ireland the background of judges does not prepare them fully for dealing with the new process in this different court. One must tread very carefully and sensitively in pursuing the role of judge in this different environment. This new departure for me has been challenging and fulfilling. One needs large measures of optimism and a real and continuing interest in people, especially on days when the reports before the court hearing are bleak and disappointing. On the days where progress is apparent there is real satisfaction. In particular when we have our graduation ceremonies, there is joy and hope together with pride for the participants and their families at the hard-won achievements. They truly deserve the respect and admiration they earn.

Conclusion

The Drug Treatment Court is to be expanded and enlarged and we look forward to this development sooner rather than later. The DTC can only ever be part of a strategy to reduce crime. It cannot eliminate the need for prison or other forms of restraint entirely, particularly in relation to certain crimes of a very serious nature.

(Edited by Johnny Connolly)

1. Irish Courts Service (1999) *First Report of the Drug Court Planning Committee.* Dublin: Stationery Office.

Quality standards in substance use education

A manual in quality standards in substance use education was launched on 10 September 2007. The manual was produced by members of the Drug Education Workers Forum (DEWF), a voluntary organisation committed to identifying and responding to the needs of voluntary, community and statutory drug education workers in Ireland. DEWF has identified a need for 'clear, practical information on best practice in substance use education in Ireland.'[1]

The aim of the manual is to provide a clear framework for practitioners of substance use education, such as workers in drug education and community education or development, youth workers, and health promotion staff, and for individuals and agencies commissioning substance use education, such as youth work management boards, school boards of management and principals, and community education organisations.

The manual was compiled by DEWF members who work in substance use education. It should be noted that it is not aimed at primary or post-primary teachers, who already have guidelines and resources in the Walk Tall and SPHE programmes. The manual is based on a substantial review of international research and best practice and provides guidelines for the development and enhancement of substance use education in school, youth-work, and community-based settings. Three working groups were set up, each designed

(L to r) Deputy Lord Mayor of Dublin, Cllr. Anne Carter, Feidhlim O Seasnáin, chair of DEWF, and Patricia O'Connor, director of the National Drugs Strategy Team, at the launch of the DEWF standards manual.

to address the needs of one of these settings. Members of the working groups had experience and expertise in those settings and came from the community, voluntary and statutory sectors. Other individuals and agencies were invited to contribute their expertise, and a series of focus groups was held with programme participants and substance use education providers.

> These standards will greatly enhance good practice and quality in this critical prevention/education pillar of the National Drugs Strategy. It certainly represents a concrete example of collective reflection, peer support and professional development that members of

Quality standards manual *(continued)*

the Forum have been engaged in since its formation. *(Finbar O'Brien, NDST chair)*

The manual is highly structured and provides a consistent framework of standards across the three education settings. Elements common to the school and youth-work settings include substance use policy, managing incidents, and staff development. Elements in the community-based setting include: education with drug service users, Travellers, and parents and guardians.

The manual also includes a 'core skills and competencies' audit for practitioners at three levels:

- foundation level, including core knowledge, attitudes and skills;
- generalist competences, including substance use education and prevention work, targeted education, advice giving, programme deliver etc.;
- specialist competencies.

DEWF is developing a training schedule to accompany the manual. It is envisioned that a two-day 'training of trainers' programme will be offered by members of the DEWF working groups. This will enable trainers to offer in their own regions a one-day training programme on use of the manual.

DEWF has emphasised the evaluation component of the manual. It is hoped that users will become involved in an evaluation process, to enable further development and enhancement of the standards over time.

The production of the manual was funded under the National Drugs Strategy. Further information can be found on the DEWF website www.dewf.ie.

It is important to remember that everyone in society has a role to play in imparting and supporting substance use education and prevention messages. Substance use education belongs in schools, families, work places and other environments; it can contribute to the achievement of broader public health goals of preventing and reducing drug related harm for both the individual and society. *(Feidhlim O Seasnáin, DEWF chair)*

(Louise Farragher)

1. Butler E, Keane R, Rowley C, Smith S (2007) *A manual in quality standards in substance use education.* Dublin: Drug Education Workers Forum.

The NDC website: results of user survey

In the autumn of 2007 The National Documentation Centre (NDC) took a survey of registered users of the NDC website to gather feedback on their experiences of using the site. The survey sought to find out:

- Who is using the NDC website, and what type of work they do
- How they learned about the site
- What their purpose was in coming to the site
- Whether they find it easy to navigate the site and find the information they need
- Whether they have any difficulties in using the site
- Which parts of the site they use most frequently
- What they think of the quantity, quality and usefulness of the information on the site
- What improvements or additional resources/services they might like to see on the site.

We sent a questionnaire by email to 1,222 registered users of the NDC, and received 288 replies – a response rate of 23.56%. We used SPSS to analyse the data.

Table 1 Satisfaction with NDC website

Answer options	Excellent	Good
Ease of using the site	30.2%	56.3%
Overall design/look	17.4%	60.1%
Quality of content	48.6%	42.7%
Quantity of content	34.7%	50.7%

Key survey findings

- One-fifth (20.3%) of the respondents work in a university or college environment, and 14.7% described themselves as researchers.
- A majority (more than 75% in each case) rated the site as 'Good' or 'Excellent' in terms of ease of use, design and layout, and quality and quantity of information (see Table 1).
- In relation to the resources currently available on the website, 77.4% (n=223) of respondents said that they were very interested in the Alcohol and Drug Research Unit publications, while 68.1% (n=196) said they were very interested in the annual national report on drug use in Ireland (see Table 2).
- 18.7% (n=53) of respondents heard about the NDC website from a colleague, and the same number, 18.7% (n=53), heard about us through an educational institution.

NDC website user survey *(continued)*

Students from the Trinity Diploma in Addiction Studies on a visit to the NDC

- 47.7% (n=135) said their main reason for using the site was work related, and 29.7% (n=84) said it was for research purposes.
- 37.1% (n=105) visit the site on a monthly basis and 28.6% (n=81) visit on a daily or weekly basis.

Views/comments

Almost all comments were complimentary of the resources and services available through the website. We will use all comments and suggestions to inform further development and improvement of the site. We are compiling a response to users' queries and will post it on the site in the near future. Our thanks to everyone who took part in this survey.

(Mairea Nelson)

Table 2 Interest in services / resources available on the NDC website

Answer options	Very interested	Interested
Alcohol and Drug Research Unit publications	77.4%	17.0%
Annual national report on drug use in Ireland	68.1%	19.8%
Current Research and Evaluation Database (CRED)	44.1%	32.6%
Directory of researchers and evaluators	20.8%	31.6%
Directory of training courses	34.0%	28.8%
E-Drugnet Ireland	43.1%	33.0%
Library services (document-supply service, provision of full text documents, reference service etc.)	60.1%	22.9%
Links page	33.0%	42.7%
NDC Database	44.1%	34.4%
NDC Newsletter	42.0%	30.6%
News page	42.4%	32.3%
Policy documents	46.2%	31.6%
Research tools	38.9%	34.4%
Thesis page	28.1%	31.6%

In brief

On 2 May 2007 the National Crime Council (NCC) published the report ***Problem-solving justice – the case for community courts in Ireland.*** It recommends the establishment of community courts, starting with inner-city Dublin. Community courts are being developed in other jurisdictions as an example of 'problem-solving justice' to deal with less grave crimes which have a material impact on the 'quality of life' of citizens, such as drug possession, public order offences, petty theft, prostitution or vandalism. www.gov.ie/crimecouncil/

In June 2007 the **Parole Board** published its annual report for 2006. The chair of the Board observed, 'It is a matter of grave concern to the Board that drugs appear to be available in many of the prisons and places of detention in the country. ... In considering whether or not to recommend temporary release (commonly known as parole) in any given case to the Minister, the Board's prime concern is the danger that the prisoner will re-offend. Quite clearly, if that prisoner is still on drugs, the risk of his or her re-offending is increased immeasurably. It is virtually impossible to see how the Board could recommend temporary release in respect of a prisoner who still requires to feed a drug addiction.' www.justice.ie

On 10 September 2007 ***Teenspace: National Recreation Policy for Young People*** was launched by the Minister for Children, Brendan Smith TD. The policy states that sport, recreation and leisure activities are effective in preventing young people from using alcohol and drugs. However, it recognises that at-risk youth – early school-leavers, socially excluded young people, Travellers – may lack positive motivation to participate and that this step must be made first. The policy also acknowledges the need for alcohol- and drug-free spaces for young people. www.omc.gov.ie

On 20 September 2007 the EAP Institute hosted its 28th annual conference, **'Drugs & Alcohol at Work – Complying with the Safety Health & Welfare at Work Act 2005'**. The conference heard that policies and procedures for handling situations where employees report for work while under the influence of alcohol and/or drugs should now be in place in all organisations, and that incidents of this nature should now be considered gross misconduct. www.eapinstitute.com

On 30 September 2007 the **Maritime Analysis and Operations Centre (Narcotics) (MAOC-N)** was established, when a treaty was signed by Ireland, the UK, the Netherlands, France, Spain, Portugal and Italy. Based in Lisbon, the MAOC-N is an international task force that will collect and analyse information on drug trafficking, enhance intelligence exchange and identify the availability of naval and other assets to facilitate national drug interdiction operations. It will focus on interdicting large maritime and aviation cocaine shipments, especially from South and Latin America. www.justice.ie

In September 2007 the **Dublin North-East Drugs Task Force** launched issue 1 of ***Uth***. www.dnedrugstf.ie

In September 2007 the **Addiction Search Engine (ASE)** was launched by the Ana Liffey Drug Project. This Google-customised search engine is designed to help users find information about addiction and drug-related issues. The ASE searches over 100 specially selected websites and the sites that they are linked to. The ASE can be accessed via the website of the Ana Liffey Drug Project. www.aldp.ie

On 1 October 2007, **World Hepatitis Awareness Day (WHAD)**, the Central and Eastern European Harm Reduction Network (CEEHRN) published a study, ***HCV infection in Europe.*** It highlights the significant inconsistencies in HCV testing and diagnosis across Europe. Only 10% – 40% of people with HCV know about their infection, according to data from different parts of Europe. (On 10 October 2007 the **Eurasian Harm Reduction Network (EHRN)** was adopted as the new name of the CEEHRN, to more accurately reflect the geographic scope of the network throughout Central and Eastern Europe and Central Asia.) www.ceehrn.org

On 10 October 2007 **the Council of Europe's Committee for the Prevention of Torture (CPT)** published a report on its 4th periodic visit to Ireland, which took place in October 2006, together with the response of the Irish government. The report stated that there was an increasing level of inter-prisoner violence, fuelled by the widespread availability of illicit drugs and the existence of a gang culture. www.cpt.coe.int/

On 18 October **2007 Business in the Community Ireland (BITCI)** launched its landmark report on best practice in corporate responsibility in Ireland in 2006. Among the case studies described was Oracle Emea Ltd, which encouraged its employees to volunteer in their local community. Over 100 Oracle volunteers participated in projects, including the painting of the Chrysalis Community Drug Project. www.bitc.ie

On 23–24 October 2007 the **Children Acts Advisory Board (CAAB)** held its national conference, 'Sharing the Task: Achieving Child Protection & Welfare through Interagency-Working', in Kilkenny. The CAAB is the new name for the Special Residential Services Board (SRSB), whose name and functions were changed in the Child Care (Amendment) Act 2007. The CAAB has broader functions, becoming an overall advisory body whose functions now include providing advice to the Minister for Children on policy issues relating to the co-ordinated delivery (and effectiveness) of services to at risk children/young people specifically under the Child Care Act 1991 and the Children Act 2001. www.caab.ie

In October 2007 the International **Drug Policy Consortium (IDPC)** published the first iteration of its ***Advocacy Guide***. In the run-up to the forthcoming UN review of its drug strategies since 1998, this advocacy guide serves as an introduction to the structure and operation of the UN drug control systems, and describes the review processes that will take place throughout 2008, culminating in a high-level political meeting in 2009. As the review process progresses, updated versions of the IDPC Advocacy Guide will be released in order to update civil society and refine the IDPC position. www.idpc.info

(Compiled by Brigid Pike)

From *Drugnet Europe*

EMCDDA releases 2007 Annual report

Cited from Drugnet Europe *No. 60, October-December 2007, p.1*

'After over a decade of rising drug use, Europe may now be entering a more stable phase. Not only are there signs that heroin use and drug injecting have become generally less common, but new data suggest that levels of cannabis use may now be stabilising after a sustained period of growth. Nevertheless, positive messages are marred by high levels of drug-related deaths and rising cocaine use.' These were the key points stressed by the EMCDDA as it launched its 2007 Annual report on the state of the drugs problem in Europe on 22 November in Brussels.

EMCCDA Director Wolfgang Götz highlighted in particular that drug use has stabilised in a number of important areas, albeit at historically high levels. In some cases, there are even signs that merit cautious optimism – such as relatively stable levels of heroin and cannabis use and mostly low rates of HIV transmission among drug injectors. There had also been a dramatic increase in countries' investment in prevention, treatment and harm-reduction activities and improved focus and cooperation in supply reduction. Furthermore, the EU is backing global actions to reduce drug problems by funding supply and demand reduction measures in third countries to the tune of at least €750 million.

HIV: overall positive assessment

Cited from Drugnet Europe *No. 60, October–December 2007, p.8*

The rate of HIV transmission among injecting drug users (IDUs) was low in most EU countries in 2005. This positive picture can be seen in the context of greater availability of prevention, treatment and harm- reduction measures and declining popularity of drug injecting in some countries. With the expansion of services, the HIV epidemics seen earlier in Europe seem largely to have been avoided. According to the Annual report: 'The situation in Estonia, Latvia and Lithuania remains a concern, but here again most of the recent data point to a relative decrease in new infections'. As a result of lower rates of transmission, the overall burden of infection resulting from injecting drug use is likely to be falling, especially in areas of high prevalence. Although injecting drug use has become less important as a route of HIV transmission, the EMCDDA estimates that, in 2005, it still accounted for some 3 500 newly diagnosed cases of HIV in the EU. This figure may be low by historical standards, yet it still represents a considerable public health problem. The report states that between 100,000 and 200,000 people who have ever injected drugs are living with HIV. The hepatitis C virus (HCV), however, is more prevalent among IDUs in the EU than HIV and more evenly distributed. The EMCDDA estimates that around 1 million people who have ever injected drugs are living with HCV.

The 2007 EMCDDA report is covered in the article '2007 report on the drugs problem in Europe', on p. 18 of this issue.

Drugs in focus – policy briefing

No. 17: Cocaine use in Europe: implications for service delivery

Cocaine use presents new challenges for Europe's drug treatment services. Although services can leverage experiences gained in responding to other types of drug problems, the pharmacology of cocaine, the social diversity of users and the concurrent use of other psychoactive substances complicate the development and targeting of responses. And unlike treatment for opioid users, there are no proven effective substitution or pharmacological treatment options currently available for cocaine users. This paper addresses a number of important issues for the delivery of services for cocaine users. How can the different groups of users be reached and helped? What type of treatment should be made available for dependent cocaine users? Are new specialised services needed, or should existing ones be adapted?

Key issues at a glance

1. Some 4.5 million European adults (1.3%) have used cocaine in the last year. Last year cocaine prevalence has shown an overall upward trend over the last decade, although with variations between EU Member States, ranging from 0.1% to 3.0% of the population.
2. Cocaine use can lead to dependence and treatment demand related to cocaine has increased. Psychiatric, cardiovascular and other health problems are also associated with cocaine use. Injecting cocaine carries the risk of transmission of blood-borne diseases such as HIV and hepatitis C.
3. Three core groups of problem cocaine users can be identified: socially well-integrated individuals; opioid users, some of whom are substitution treatment clients; and marginalised crack users.
4. These groups differ in drug use patterns, health and living conditions. Their needs range from access to information about cocaine-related risks to specific treatment or harm reduction interventions.
5. Current responses to cocaine-related problems draw largely on existing services targeted at opioid use and drug use in recreational settings. These existing services may need adapting to meet the specific needs of cocaine and crack users.
6. Improvements could include: specific cocaine and crack strategies; training and research on the treatment of cocaine dependence; outreach interventions; and tailored treatment services for specific groups of cocaine and crack users.

Conclusions and policy considerations

1. Specific strategies targeting cocaine or crack cocaine use should be developed in areas where the extent of the problem, such as in some European countries and cities, requires a concerted response. Elsewhere, drug policies should address the growing diversity in drug use patterns and needs of problem drug users.

Drugs in focus (continued)

2. Prevention and harm reduction approaches related to cocaine use need to be developed, in particular information on risks (cardiovascular, psychiatric, elevated toxicity of some forms of polydrug use). Both occasional and regular cocaine users should be targeted.
3. Interventions to reach and help socially integrated problem cocaine users can be developed by adapting existing services or, in some cases, providing dedicated treatment services.
4. Crack users, and other marginalised populations of drug users, should have access to harm reduction outreach interventions including service referral.
5. In all treatment settings, training in psychosocial interventions should have high priority as this kind of intervention has shown the best results. Exchanging knowledge and best practice among clinicians and other drug workers should be encouraged.
6. Research on psychosocial interventions and on new pharmaceutical agents to treat cocaine-dependent clients should be promoted. There is also an urgent need to better understand polydrug use involving cocaine, its multiple variants and consequences.

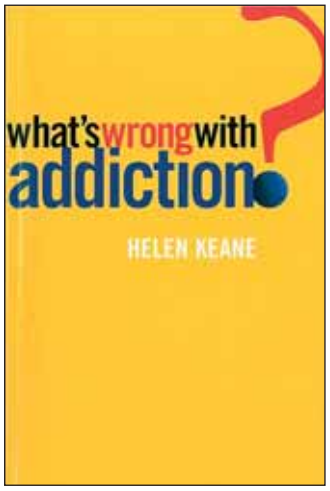
Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). ***Drugs in focus*** is a series of policy briefings published by the EMCDDA. Both publications are available at www.emcdda.europa.eu.

If you would like a hard copy of the current or future issues of either publication, please contact:

Alcohol and Drug Research Unit,
Health Research Board,
Knockmaun House,
42–47 Lower Mount Street,
Dublin 2.
Tel: 01 2345 127
Email: adru@hrb.ie.

Recent publications

Books



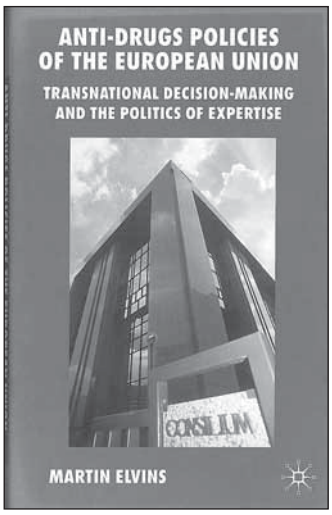
What's wrong with addiction?
Keane H
Melbourne University Press 2002, 228 pp.
ISBN 0 522 84991 1

This book takes the view that, while there is a pervasive theme of addiction as a disorder marked by physical, psychic and moral pathology, the 'wrongness' of addiction is not fixed nor indeed obvious. It varies according to context: the type of addiction and the type of addicted body, and the type of discourse. The author presents the argument that many of the harms, both individual and social, that are associated with addiction are secondary consequences, rather than essential and inevitable elements of the addictive experience. She examines why it is bad to be an addict and what the wrongness of addiction is, focusing on how the problems and experiences we group under the term addiction are wrong. The book exposes strains in contemporary oppositions between health and disease, between the natural and the artificial, between order and disorder and between self and other.

Chapter 1 discusses pharmacological understandings of drugs and neurological models of addiction. Chapter 2 explores the substance dependence syndrome of medical discourse and the problems of diagnosing dependence as a medical disorder. Chapter 3 deals with popular addiction discourse and its engagement with issues of selfhood. Chapters 4, 5 and 6 apply the concept of addiction to substances and behaviours other than drugs or alcohol – smoking, food and sex. Chapter 7 questions the promise of happiness and health to be found in the 'utopia of recovery' as presented in popular addiction discourse.

The final chapter summarises the argument developed in the book, suggesting that the expansion of addiction discourses should be resisted or at least questioned. The author argues that the development of new and wide-ranging addictive pathologies cannot help but strengthen the hold of medical expertise and therapeutic authority over people's conduct and desires. In her view, the growth of addiction demands scrutiny because it is a notion through which specifically liberal forms of political power and government regulation operate efficiently and seductively.

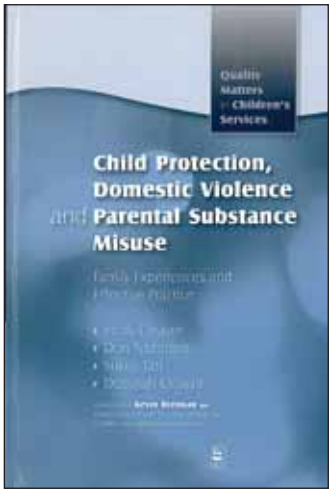
Recent publications (continued)



Anti-drugs policies of the European Union: transnational decision-making and the politics of expertise
Elvins M
Palgrave Macmillan 2003, 227 pp.
ISBN 0 333 98213 4

This book traces the evolution of enforcement-based anti-drugs policies at EU level from the late 1960s to the present. It considers their development in the contexts of European integration and the broad harmonisation of international policies against drug trafficking. The author examines the underlying logic of the policy process, and assesses the influence of drug issues on the emergence of wide-ranging EU security institutions such as Europol. He states that the primary rationale employed by policy makers is based on some notion of protection: from the impact of drugs on public health, from crime associated with drug use, and from the use of violence and corruption by traffickers. He goes on to argue that this shared rationale has led to a clear convergence in drug-trafficking policies adopted by states across the world. By way of contrast, and in spite of recent UN efforts, there is no international consensus on the appropriate form, mix or efficacy of 'positive control' measures – particularly those aimed at reducing consumption, from education to harm-reduction techniques such as needle-exchange programmes – hence the right of initiative is left primarily in the hands of national (and to a large extent regional and local) authorities.

The author assesses the influence of transnational networks of expertise on policy development, and explores questions about the changing nature of state power and state sovereignty under globalisation. He examines the practices of contemporary European governance and raises concerns about secretive and anti-democratic features of inter-governmental EU decision making. The wider contention of the book is that the key to understanding contemporary state power in the area under discussion lies in understanding the policy-making actors whose control over knowledge is vital in providing the rationale for policy and in creating and sustaining a normative framework through which policy decisions are filtered by the political decision makers of national states. The book assesses the extent to which a pseudo-scientific 'technical' approach has become the dominant means through which policy 'solutions' for complex transnational problems (such as drug trafficking) are mediated.



Child protection, domestic violence and parental substance misuse
Cleaver H, Nicholson D, Tarr S and Cleaver D
Jessica Kingsley Publishers 2007, 232 pp.
ISBN 978 1 84310 5824

This book is based on a two-year study commissioned under the UK government's Quality Protects research initiative. The study examined how one of the objectives of that initiative, Protection from Significant Harms, is working for children and young people referred to care services.

In reporting on this study, the book focuses on how child protection practices and procedures respond to children and families affected by domestic violence and/or parental substance misuse. It reveals the vulnerability of children in such situations and the negative impact on their health and development, on the adults' capacity to undertake key parenting tasks, and on family functioning, housing, income and social integration. The book describes the extent to which services work together in such cases and identifies factors that support collaborative working. It includes parents' own voices and allows them to explain what help they feel would best support families in similar situations. The authors also explore the response of children's services, and the extent to which current local authority plans procedures, joint protocols and training effectively support information sharing and collaborative working. From the findings, they draw implications for policy and practice in both children and adult services. This book will be of interest to professionals working to promote the welfare and well-being of children and those working with vulnerable adults and parents.

Recent publications (continued)

Journal articles

The following abstracts are cited from recently published articles relating to the drugs situation in Ireland.

Using environmental analytical data to estimate levels of community consumption of illicit drugs and abused pharmaceuticals

Bones J, Thomas KV and Paull B
Journal of Environmental Monitoring 2007; 9(7): 701–707

A solid phase extraction (SPE) method was developed and applied in conjunction with a previously reported liquid chromatography tandem mass spectrometry procedure in order to establish the presence of illicit drugs and abused pharmaceuticals in treated wastewater and surface water samples at the ng L–1 level. The procedure was applied in Dublin, Ireland, and rapidly expanding commuter towns in the surrounding counties. Cocaine was detected in 70% of the collected samples in the range of 25–489 ng L–1; its primary metabolite, benzoylecognine (BZE), was also detected, in the range of 22–290 ng L–1. Other substances detected included morphine, Tempazepam and the primary metabolite of methadone.

Health care professionals' knowledge and attitudes regarding substance use and substance users

Kelleher S
Accident and Emergency Nursing 2007; 15(3): 161–165

In Ireland one in four (28%) of those attending hospital emergency departments have substance-abuse-related injury/illness and one in eight (13%) present in a state of clinical intoxication. Health care professionals working in emergency departments are frequently exposed to patients with substance use problems and are in ideal positions to provide early diagnosis and treatment. The success rate in detecting these patients is, however, disturbingly low (25–50%) and many substance-use problems are misdiagnosed or remain undetected. International studies that focus on primary care and addiction within the mental health sector suggest that health care professionals' knowledge and attitudes regarding substance use and substance users may negatively influence the care that these patients receive. There is a dearth of empirical research on this issue, internationally and in Ireland, particularly in emergency department settings.

Heroin epidemics, treatment and ODE modelling

White E and Comiskey C
Mathematical Biosciences 2007; 208(1): 312–324

The UN, EU and World Health Organization (WHO) have consistently highlighted in recent years the ongoing and persistent nature of opiate, particularly heroin, use on a global scale. Authors have emphasised the significant impact such an epidemic has on individual lives and on society. National prevalence studies have indicated the scale of the problem, but the drug-using career, typically consisting of initiation, habitual use, a treatment–relapse cycle and eventual recovery, is not well understood. This paper presents one of the first ODE models of opiate addiction, based on the principles of mathematical epidemiology. The aim of this model is to identify parameters of interest for further study, with a view to informing and assisting policy-makers in targeting prevention and treatment resources for maximum effectiveness. An epidemic threshold value, R0, is proposed for the drug-using career. Sensitivity analysis is performed on R0 and it is then used to examine the stability of the system. A condition under which a backward bifurcation may exist is found, as are conditions that permit the existence of one or more endemic equilibria. A key result arising from this model is that prevention is indeed better than cure.

Hospital admission for acute pancreatitis in the Irish population, 1997–2004: could the increase be due to an increase in alcohol-related pancreatitis?

O'Farrell A, Allwright S, Toomey D, Bedford D and Conlon K
Journal of Public Health 2007; 29(4):398–404

The objective of this research was to investigate trends in the incidence of acute pancreatitis by examining emergency admissions to acute public hospitals over an eight-year period; to compare trends for alcohol-related pancreatitis admissions with admissions related to biliary tract disease; and to profile the patients admitted with an acute pancreatitis diagnosis.

All in-patient emergency admissions for which acute pancreatitis (ICD-9-CM Code 577.0) was recorded as principal diagnosis were identified for years 1997–2004 inclusive. Alcohol-related acute pancreatitis admissions (with alcohol misuse recorded as co-morbidity) were identified using ICD-9-CM-codes 303 and 305. Admissions with biliary tract disease recorded as co-morbidity were identified using ICD-9-CM codes 574.0–576.0 inclusive. Pearson's {chi}2-test was used to compare proportions in groups of categorical data and {chi}2-tests for trend were used to identify linear trends.

There were 6291 emergency admissions with a principal diagnosis of acute pancreatitis in the eight-year study period, with 622 admissions in 1997 compared to 959 in 2004, an increase of 54.1%. Age standardized rates rose significantly from 17.5 per 100 000 population in 1997 to 23.6 in 2004 ($P < 0.01$ for linear trend). There were 1,205 admissions with alcohol misuse recorded as a co-morbidity, increasing from 13.9% (87/622) of acute pancreatitis admissions in 1997 to 23.2% (223/959) in 2004. This increase was significantly greater than that observed in admissions related to biliary tract disease, 19.6% (122/622) in 1997 to 23.5% (225/959) in 2004. Rates for total acute pancreatitis admissions were highest in those aged 70 years and over; the majority (3563, 56.6%) were male, with a mean age of 51.1 years (SD 19.9); the mean age for male admissions was significantly younger than that for female admissions (49.1 versus 53.6 years, $P < 0.001$). However, for alcohol-related admissions, rates were highest in those aged 30–49 years, and patients admitted with alcohol misuse recorded were significantly younger than those who did not have alcohol misuse recorded (42.0 versus 53.2 years, $P < 0.001$). Median length of stay was seven days. The increasing trend in alcohol-related acute pancreatitis parallels the rise in per capita alcohol consumption. Given the continuing rise in binge drinking, particularly among young people, this is a cause for concern.

(Compiled by Joan Moore and Louise Farragher)

Upcoming events

(*Compiled by Louise Farragher* – lfarragher@hrb.ie)

January

31 January 2008

The First National Service User Involvement Conference: Nothing About Us Without Us!
Venue: Birmingham

Organised by / Contact: Drink and Drug News

Tel: +44 (0)20 7463 2081

Email: info@cjwellings.com
www.drinkanddrugs.net

Information: This first national service user involvement conference will bring together policymakers, service user co-ordinators from drug action teams, and drug and alcohol service users from all over the UK. The event is organised by *Drink and Drugs News* magazine (the fortnightly magazine for the drug and alcohol field) in partnership with The Alliance, the organisation that provides advocacy and training to people involved in drug treatment. The purpose of this event is to construct a meaningful dialogue and a shared agenda around service user involvement, during the transition period of a new drug strategy. We will demonstrate that service users' involvement is crucial to shaping drug treatment and policy of the future, and help those who work with service users to do their job more effectively. The day's events will help to define the way forward for service user involvement in the drug and alcohol field and is an essential event for everyone who cares about getting it right.

January–March

Managing the Performance, Safety and Health Risks of Employee Drug and Alcohol use
Organised by / Contact: Anita Furlong, EAP Institute, 143 Barrack Street, Waterford.

Tel: +353 (0)51 855733
Fax: + 353 (0)51 879626

Email: maurice@eapinstitute.com
www.eapinstitue.com

Thursday 17 January 2008
Venue: Stillorgan Park Hotel, Dublin

Thursday 21 February 2008
Venue: Clarion Hotel Suites, Ennis Road, Limerick

Thursday 6 March 2008
Venue: Radisson Hotel, Little Island, Cork

Information: The Safety, Health and Welfare at Work Act 2005 was signed into law in June 2005. Included in the Act are new duties on employees as follows:

- Not to be under the influence of an intoxicant (defined as drugs and alcohol) to the extent that they endanger their own or other persons safety;
- Not to report or be in an unfit condition at their place of work due to the consumption of an intoxicant to the extent that they endanger their own or another's safety. An employer may remove an employee from the workplace who reports for duty in such condition. Safety statements should now be updated to reflect this new risk.

The purpose of this seminar is to outline the impact of drug impairment in the workforce and practical steps in the recognition and treatment of employees whose behaviour presents risks to themselves and others while at work.

April

3–4 April 2008

Second International Conference of the International Society for the Study of Drug Policy
Venue: Lisbon, Portugal

Organised by / Contact: The International Society for the Study of Drug Policy
www.issdp.org/conferences.htm

Information: This event is being supported by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Instituto da Droga e da Toxicodependência (IDT). The four themes of the conference will be:

- Developing drug policy evaluation: where are we?
- Defining drug policy models/types
- The rise of security and public nuisance concerns
- The integrated approach to both licit and illicit drugs: From theory to practice.

May

11–15 May 2008

International Harm Reduction Association 19th International Conference: Towards a global approach
Venue: Palacio de Congresos, Fira de Barcelona, Spain

Organised by/ Contact: International Harm Reduction Association (IHRA)

Tel: +44 (0) 207 462 6997
Fax: +44 (0) 207 462 6999

Email: info@ihraconferences.com
www.ihra.net/Barcelona/Home

Information: IHRA's harm reduction conferences have been held around the world every year since 1990, and the next event takes place in Barcelona.

Over five days, this conference will be the main meeting point for those interested in harm reduction, and an invaluable platform for debate, discussion, and the dissemination of new and evolving good practice in addressing drug use and associated harm.

29–31 May 2008

EUROPAD 8 Conference
Venue: Kempinski Hotel, Sofia, Bulgaria

Organised by / Contact: EUROPAD: European Opiate Addiction Treatment Association
www.europad.org

Information: Further details to be announced.

July

7–9 July 2008

Beyond 2008 Forum
Venue: Vienna, Austria

Organised by / Contact: Vienna NGO Committee
Email: www.vngoc.org
info@vngoc.org

Information: Beyond 2008 is a joint initiative of the Vienna and New York NGO Committees on drugs to facilitate an effective contribution from NGOs to the UNGASS Review. The target date of 2008 agreed at the 1998 UNGASS on Drugs for the achievement of 'significant and measurable results' presents an opportunity for the NGO community to reflect on its own achievements in drug control, exchange ideas on promising new approaches, reach agreements on ways to work together and make recommendations to multilateral agencies and UN member states on future directions for drug control. Building on past experience, the Vienna NGO Committee will host Beyond 2008 to contribute to the 1998–2008 review and agenda-setting exercise being undertaken by the Commission on Narcotic Drugs (CND).

The Alcohol and Drug Research Unit (ADRU) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug situation, its consequences and responses in Ireland.

The ADRU maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The unit also manages the National Documentation Centre on Drug Use.

The ADRU disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland*, and other publications. Through its activities, the ADRU aims to inform policy and practice in relation to drug use.

***Drugnet Ireland* mailing list**

If you wish to have your name included on the mailing list for future issues of *Drugnet Ireland*, please send your contact details to:

Alcohol and Drug Research Unit
Health Research Board
Knockmaun House
42–47 Lower Mount Street
Dublin 2
Tel: 01 2345 127
Email: adru@hrb.ie

Please indicate whether you would also like to be included on the mailing list for *Drugnet Europe* or *Drugs in focus*.

Have your contact details changed?

We want to make sure that our mailing lists contain the correct contact details for all our readers. If there have been any changes to your title, organisation, address (postal or email), or telephone number, please let us know so that we can update our records. You can contact the Alcohol and Drug Research Unit by telephone at (01) 2345 127, or by email at adru@hrb.ie.